

The California Mental Health Parity Act Toolkit

A Guide to Appealing Health Plan Mental Health Care Denials

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Acknowledgement

In September 2010, the Parity Implementation Coalition published their first edition of the *Parity Toolkit for Addiction & Mental Health Consumers, Providers & Advocates*. This excellent toolkit was created to help individuals navigate the appeal process to ensure that health plans comply with the rights and benefits provided under the federal parity law (the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* (MHPAEA)). We would like to thank the Coalition for their hard work and for allowing us to use their toolkit as a guideline for our toolkit, which focuses on California state law. The authors recommend any reader to locate and use the Parity Implementation Coalition's toolkit when appealing a decision that is covered by federal law.

We also would like to thank Mental Health Advocacy Project, Inc., Mental Health Advocacy Services, and Legal Aid Society of San Diego for their contributions and support for this project.

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Introduction

This toolkit provides practical information and tips to help people get the mental health services they need. This toolkit is for people with private health plans regulated by the State of California and subject to the requirements of the California Mental Health Parity Act. It covers the following:

- what mental health services your health plan must cover under the California Mental Health Parity Act;
- what additional mental health services your health plan may cover, and
- how to appeal when your health plan denies your request for a mental health service that you need.

There are two mental health parity laws that apply to Californians, a federal parity law and a state parity law. Which parity law applies in your situation will depend on the type of health plan you have and who is providing the coverage. The focus of this toolkit is California's mental health parity law. See page 4 for a description of the health plans covered by the California law. For the toolkit addressing the federal mental health parity law, please see <http://parityispersonal.org/Parity-Toolkit>.

This publication does not cover Medi-Cal. For information about your rights to mental health parity under Medi-Cal, see our website at <http://www.disabilityrightsca.org/CalMHSA/CalMHSAParity.html>.

The toolkit first talks about what parity means and how it affects a consumer's mental health plan coverage. The next section is about how to use the toolkit. It then discusses the California Mental Health Parity Act. The last major section is about the appeals process, and it includes sample letters and appeal documents.

What is mental health parity?

Mental health parity means that a health plan must provide equal coverage for mental health and physical health. For example, health plans cannot make you pay more for mental health therapy appointments than it makes you pay for physical health appointments. This doesn't mean that the

services provided are the exact same; mental health services don't always have an equal in physical health services. What it means is that a health plan cannot make it more difficult to receive medically necessary mental health services. It also means a health plan cannot make it more expensive to the consumer to receive those services.

How to Use This Toolkit

The information in the toolkit is a guide to the process of appealing a negative decision by a health plan subject to the California Mental Health Parity Act. The first half of the toolkit gives information about the law, the appeals process and general reference information.

The second half is the Appendix. The templates in the Appendix are meant to be carefully reviewed by consumers, their families, their advocates and providers and altered to fit the facts that make each situation unique.

Each template includes an opinion letter drafted by the team of legal services agencies that have worked together to create this toolkit. We encourage you to use the letters to help you support your position when filing an appeal. These letters also contain customizable sections where you can include specific facts to tailor the letters to your specific case.

Also included are checklists designed to assist health care providers with resolving disputes with the health plans. The authors would like to thank the Parity Implementation Coalition for providing guidance on these checklists. The checklists have been developed based on the Coalition's years of experience in assisting with mental health parity issues. Providers should pay particular attention to the managed care appeals checklist located in the Appendix on page 24.

Overview of California Mental Health Parity Act (CMHPA)

Brief History of the CMHPA

The California Mental Health Parity Act, Assembly Bill 88 (AB 88), was signed into law in 1999. It requires that every health plan that offers hospital, medical or surgical coverage must provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses as well. The legislative history of AB 88 includes a letter from Assemblywoman Helen M. Thomson and Senator Don Perata to clarify the intent of the Act. It says, in part, that “AB 88 was introduced in the spirit of bringing about fairness and equal treatment by the health plans and insurance industry” for those persons who have a severe mental illness. 6 Assemb. Journal, Cal. Leg., 1999-2000 Reg. Sess., 8115 (Aug. 23, 2000), Cal. Health & Safety Code § 1374.72 note, Cal. Ins. Code § 10144.5 note (West 2014).

Who is covered by the CMHPA

The California Mental Health Parity Act applies to all California health plans issued, amended or renewed on or after July 1, 2000, with some exceptions. It does not apply to “self-funded” employment-based plans, Medicare, Medi-Cal, Department of Veterans Affairs (VA), or federal employee health plans.

The California law requires that all medically necessary mental health services and treatments are covered equal to medical services. Equal does not mean a one to one comparison of services, but an equal quality of coverage. *Rae v. Blue Cross of California*, 226 Cal. App. 4th 1209, 1238, 172 Cal. Rptr. 3d 823, 845 (2014).

The law requires that the benefits provided under the health plan be equal between medical and mental health services. The benefits that are covered by the statute include:

1. Outpatient services
2. Inpatient services
3. Partial hospital services
4. Prescription drugs, but only if there is a drug plan offered. There is no requirement to create a drug plan to comply with the parity law.

The terms and conditions that must be applied equally to all benefits include, but are not limited to:

1. Maximum lifetime benefits
2. Co-payments
3. Individual and family deductibles

This means that if the co-payment for an office visit with your physician is \$30, then the co-payment for an office visit with your therapist also must be \$30.

There is, however, a limit to who receives the benefits of the parity law. The statute requires parity for all adult persons with a “severe mental illness” as defined in the Mental Health Parity Act. For adults, the illnesses covered under the Act are:

1. Schizophrenia
2. Schizoaffective disorder
3. Bipolar disorder (manic-depressive illness)
4. Major depressive disorders
5. Panic disorders
6. Obsessive-compulsive disorder
7. Pervasive developmental disorder or autism
8. Anorexia nervosa
9. Bulimia nervosa

Children with a “severe emotional disturbance” are also protected by the California Mental Health Parity Act. “Severe emotional disturbance” is defined more broadly than “severe mental illness” to include any disorder in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance abuse disorder or developmental disorder. The emotional disturbance must also meet the criteria in Welfare & Institutions code § 5600.3(a)(2). This means that the “severe emotional disturbance” must result in a substantial impairment in two or more categories, and inappropriate behavior according to developmental norms.

Below are some examples of how the California Mental Health Parity Act requires equal treatments and services for mental health and medical/surgical health.

A person with a diagnosis of major depression or anorexia nervosa has submitted a request for prior authorization for outpatient intensive therapy. The outpatient intensive therapy must be provided comparable to the provision of outpatient intensive therapy for someone with a physical disability.

A child with a diagnosis of severe bipolar disorder will be able to receive medically necessary recommended in-home, intensive support services of the same quality as other outpatient medical/surgical care.

A person with a diagnosis of schizophrenia will be able to receive the same care in regards to utilization and out-of-pocket expense for an intensive, inpatient hospitalization as someone with a need for intensive, inpatient hospitalization for a medical/surgical condition.

Appeals Process

Overview

You have a legal right to challenge a coverage denial by a health plan, no matter what kind of health plan you have. For example, you have a right to challenge a coverage denial if you have an individually-purchased plan or an employer-paid plan. This includes plans available directly, or through a broker or an exchange, such as Covered California. Every plan is required to provide a process to reconsider or appeal a denial of coverage. The only question should be who to file the appeal with and which parity law applies. If your health plan is regulated by the State of California, and you have been diagnosed with one of the nine mental illnesses listed on page 5, or a severe emotional disturbance, as defined on page 5, this toolkit provides the materials to help you with your appeal. If you fall outside of these criteria, you most likely fall within the federal parity laws and the federal toolkit would be the best resource. The federal toolkit can be located at <http://parityispersonal.org/Parity-Toolkit>.

Regulating agencies

If you have a health care service plan, also called a managed care plan, or a Blue Cross or Blue Shield preferred provider organization (PPO) plan, your plan is probably regulated by the California Department of Managed Health Care (DMHC) and DMHC rules apply to your plan. If you have an indemnity insurance policy (also called a “fee-for-service” plan) including a PPO plan (other than a Blue Cross or Blue Shield PPO plan) your plan is probably regulated by the California Department of Insurance (CDI, or DOI), and CDI rules apply to your plan. The California Mental Health Parity Act provisions administered by DMHC and CDI are virtually the same, but are found in different places in the California codes. The statutes administered by DMHC are found in the California Health and Safety Code and the statutes administered by CDI are found in the California Insurance Code. DMHC and CDI also apply federal mental health parity protections to all plans covered by the California Mental Health Parity Act and to all plans regulated by them that provide non-mandated mental health and substance use benefits.

If you receive your mental health services through Medi-Cal, the California law may not apply. However, the federal mental health parity protections apply, and the information in the federal parity toolkit applies. In addition,

there is a separate process for Medi-Cal administrative hearings that is beyond the scope of this publication. For more information about the Medi-Cal appeal process, please see the Helpful Links page below.

If you receive your mental health services through a self-funded employer-based plan, (such as a large private employer plan, a state or local government plan, or a union plan) only the federal mental health parity protections apply, and the information in the federal parity toolkit applies. It is sometimes difficult to determine if a plan is self-funded or not. Usually, an employer or union will hire a third-party administrator (TPA) to operate the plan. The TPA is usually a health plan, for example, Blue Cross, Health Net, or UnitedHealthcare. The summary plan description (SPD) for your health coverage will be issued by this health plan. Ask your plan administrator if the plan is self-funded or not.

Finally, federal government plans have separate parity requirements. The state requirements do not apply to these plans. Federal government plans include Medicare, Medicare Advantage, Medicare Supplement, Veterans Affairs (VA), CHAMPUS, and Federal Employee Health Benefits Program (FEHBP) plans administered directly by the federal government or through private insurers. Check your evidence of coverage or summary plan description documents to determine what your appeal rights are. You can also find information about appeal rights on the various plan websites.

Know your coverage documents

Understand the health plan coverage

Knowing what your plan will and will not cover, prior to a procedure or doctor's appointment, allows you to make more informed decisions about your health care. Depending on your plan and your benefit, this information will be outlined on the health plan's website or is available from your plan administrator or your employer's human resources (HR) department. Information about what benefits your plan covers, and how to access care is usually outlined in a packet of information called the "Evidence of Coverage" (EOC) or "summary plan description" (SPD). Ask your broker, your plan administrator, or your employer's human resources department where to find it if you cannot locate your EOC or SPD documents.

Know when you need to obtain prior authorization

It is your responsibility to know when you need to obtain prior authorization for a procedure or treatment, or to see a specialist, and to make sure you and/or your provider receive approval. You can also find this information in the benefit plan documentation or by calling your health plan's customer service.

Denial

It is not unusual for some claims to be denied or for health plans to say they will not cover a test, procedure or service that doctors order. When a health plan denies a claim, either through the prior authorization process or after the service has been completed (post-payment audit), you will get a denial notice. The notice will inform you that the health plan will not pay for the service and the reason for the denial. If the denial is based on medical necessity, the notice must also contain the section of the medical necessity guidelines that applies to your situation.

If you do not receive a notice, but you have been told by a provider or other party that your service or treatment has been denied, contact your health plan. There are only a few situations where the health plan is not required to provide a written notice. If you have been denied coverage because of a specific exclusion, for medical necessity, or for an experimental or investigational treatment, the health plan must provide written notice of the denial. When contacting your health plan remember to write down who you spoke to, when you called and what happened in the call. If the health plan confirms the denial, ask that they send you the denial in writing. If the plan refuses to send a written denial, or fails to send you the written denial, you can call the regulating agency for help. (See page 23 for helpful links) The discussion about which agency to call is above on page 7.

Your first step when you receive a denial notice should be to refile the claim together with a copy of the denial notice. You may need a note or letter from your doctor or other provider to explain or justify what it is you need. Sometimes all that is needed is the service or treatment to be coded differently. If your challenge is not successful, you may need to:

- Delay your payment for the treatment until the matter is resolved.
- Re-submit the claim a third time and request a review.

- Ask to speak with a health plan supervisor who may have the authority to reverse a decision.
- Request a written response from the health plan explaining the reason for the denial.
- Get help from a customer service representative of the state agency that regulates your health plan. (See page 23 for helpful links).
- Formally appeal the health plan’s denial in writing, explaining why you think the health plan should pay for the treatment.

When contacting your health plan (i.e., when seeking general information to begin the appeal process) it’s important to try to develop a good working relationship with the plan representative(s). Below are some tips for getting answers to these coverage-related questions.

- Speak with your health plan’s customer service department.
- Ask for the name of the person with whom you are speaking each and every time you call.
- Make a note of the person’s name and the date and time of the call.
- Ask if there is a “reference number” for your call, and write down this number, if there is one.
- Ask your health care provider for help.
- Talk with the consumer advocacy office of the government agency that regulates your plan. Ask for and write down the names of the people you speak to. See the Helpful Links section of this toolkit for contact information.
- Learn about the health plan laws and regulations that protect you. See the Helpful Links section in this toolkit for further information.

Filing an appeal

Critical Information You Need BEFORE You File Your Appeal

BEFORE you call your health plan, make sure you have the following information.

1. Know what type of health plan you have.
You need to know what type of health plan you have. This can be individual coverage, self-funded employer-based coverage, small group coverage, large group coverage or a public plan. See the

checklist titled “Checklist for My Health Plan Coverage” on page 25 in the appendix.

2. Understand the terms of the plan’s coverage documents (and what mental health and non-mental health benefits the plan does and does not cover).
3. Obtain the medical necessity criteria for both the mental health and comparable medical benefit so you can compare how coverage decisions are made for both types of benefits.
4. Obtain the plan’s reason for the denial of care.

Internal Appeal

Health plans have one and sometimes two levels of internal appeals. To file an appeal, most health plans have a standard form. Often the health plan will include the appeal form with the denial notice, or provide you information on how to get the form. Use the checklist on page 25 to ensure that you are providing all the information the health plan will need to properly evaluate the denial.

When filing your appeal, remember these tips:

- Be persistent. Don’t give up. – Denials are often overturned on appeal. You may have to go through several steps in the appeal process to get the denial overturned.
- Keep you appeals factual and brief, but make sure you provide complete information.
- Meet all deadlines for filing an appeal.
- Keep detailed records. You can use the tracking sheet on page 25 to help with this.
- Ask for help from your health care providers.

External Review

If the internal appeal is not successful, in many cases you can request an external review. Your health plan will provide information about the right to external review in your Evidence of Coverage or Summary Plan Description documents. During an external review or “Independent Medical Review” (IMR), your denial is reviewed by doctors who are not part of your

health plan. The agency that regulates your health plan is responsible for the external review.

You can apply for an IMR if your health plan denies, changes, or delays a service or treatment because:

- The plan determines the treatment is not a covered benefit under the terms of the plan;
- The plan determines the treatment is not medically necessary;
- The plan will not cover an experimental or investigational treatment for a serious condition;
- The plan will not pay for emergency or urgent medical services that you have already received.

Urgent Health Situations

If you are in an urgent health situation and your health plan has denied needed care, the appeals process can be speeded up. These are situations where waiting for the standard appeals process could seriously jeopardize your life or your ability to regain maximum function.

In this situation, you can request both an internal and external review at the same time. The timeline for a final decision is also shortened. A final decision must be reached as quickly as your condition requires, within a maximum of four (4) business days.

Arbitration

Your health plan may offer, or, in some cases, require that you settle your differences through a process called arbitration. This is where two parties present their views to a neutral third party – an arbitrator – who will then decide how to settle the differences. Your Evidence of Coverage or Summary Plan Description will have information about the arbitration process and whether it is binding or non-binding. Binding arbitration means that everyone agrees ahead of time to abide by the arbitrator's decision. Non-binding arbitration means the decision is advisory only, and you don't lose any other appeal rights.

If your health plan offers voluntary arbitration, you may or may not use it, as you choose. If you decide not to use the voluntary arbitration, it does not affect your rights to any other plan benefits, nor can your health plan use your decision against you in any subsequent appeals.

If your insurance plan makes arbitration mandatory, California may regulate how the arbitration can be used. The agency that regulates your plan will be able to provide you additional information about the state requirements. The Helpful Links section has contact information for the Department of Insurance and the Department of Managed Health Care Services.

Steps to Take During an Appeal

Step #1 - Ask your provider to help you:

Your provider has the resources and knowledge to help you support your claim. S/he is able to provide information about your treatment needs that may convince your plan to cover your care or treatment. If your provider recommends a course of treatment, s/he has a professional obligation to help you get authorization or payment for the treatment from your health plan. Your provider may also have a legal obligation to help you with this as well.

Step #2 - Make sure your provider requests a special, expedited appeal for emergencies (see section on urgent health situations above):

Emergency care cannot be put off because of standard paperwork or decision-making processes. Most health plans provide this special appeals process, so use it when necessary.

Step #3 - Confirm with the health plan that your services will be covered during the appeal:

If this is not possible, ask what your financial obligations would be for these services if the appeal is unsuccessful so that you may discuss other options with your provider(s), as necessary.

Step #4 - Request, or have your provider request, written notification of the reasons for denial:

Your health plan should send both you and your provider a written explanation of the reasons care is being denied. This notice should include a description of the information required for your treatment to be approved. By providing this information in writing, it reduces the chances that there will be a miscommunication between the health plan and you and your provider. This is a new right under the parity law. If you do not receive this within 30 days, complain to the entity regulating your health plan.

Step #5 - Utilize the templates in this toolkit:

Section 5 of this toolkit contains sample letters for appealing the most commonly denied mental health/substance use disorder claims and accompanying legal justifications.

Step #6 - Make sure that you and your provider(s) meet all deadlines:

If your treatment is denied because either you or your provider missed a utilization review or appeals deadline, that denial is rarely overturned, even if the health plan agrees that treatment is necessary.

Conclusion

We know and understand that the appeal process can be frustrating and tedious. You will have to call your health plan, record all the information provided in those calls, track all your documents and write letters. But it is doable, and often quite successful. Get a notebook and find a place in your house to keep everything. Write notes of every call you make. Save every letter you receive. Stay calm and be pleasant. Take it one day at a time. Let us know if we can help. The partnering organizations' contact information is in the Helpful Links section.

Terms to Know

Appealing a Claim: The process to contest a denied medical or mental health claim. Most health plans have their own process and timeline.

Balance Billing: The amount you could be responsible for (in addition to any co-payments, deductibles or coinsurance) if you use an out-of-network provider and the fee for a particular service exceeds the allowable charge for that service.

Carrier: The health care service plan or health insurance company that issues your health plan coverage.

Carve-Out: - An independent managed behavioral health organization that manages mental health or substance use benefits separately from the plan's medical benefits.

Claim: A description of care provided, or to be provided, or a request for payment, typically submitted by the provider to the patient's health plan. Claims are reviewed by the health plan in order to determine whether the services are covered and ultimately whether the health plan will authorize payment for the services to the provider.

Classification: One of the 4 categories of benefits required under the California Mental Health Parity Law (i.e., inpatient, outpatient, partial hospitalization, or prescription drug coverage).

Clinical Practice Guideline: A utilization and quality management tool designed to help providers to make decisions about the most appropriate course of treatment for a particular patient with a particular condition or conditions.

Co-payment: The dollar amount that a patient with health care coverage is expected to pay at the time of service.

Deductible: A dollar amount (usually an annual amount) a patient with health care coverage must pay before the health plan will make any payments.

Denied Medical Claim: Rejection of a request for reimbursement of health care services delivered to the patient with health care coverage. The health

plan often informs the patient of the rejected claim and explains why the services are believed to be outside of the scope of those covered by the health plan.

Effective Date: The date your health coverage is to actually begin. You are not covered for any services until the effective date.

Employee Assistance Programs (EAPs): Mental health counseling services that are sometimes offered by health plans or employers. Typically, individuals or employers do not have to pay directly for services provided through an employee assistance program.

Employee Retirement Income Security Act (ERISA): A comprehensive federal law that regulates employee welfare benefit plans, including self-funded health plans, and establishes the rights of health plan participants, requirements for the disclosure of health plan provisions and funding to participants, and standards for the investment of plan assets.

Evidence of Coverage (EOC): A packet of information about your health plan, which summarizes covered and excluded benefits. This packet outlines the rules and procedures for accessing benefits through your health plan, and also describes the grievance and appeals processes. Under some plans, this type of information is called a Summary Plan Description (SPD).

Exclusions: Specific conditions, services or treatments, listed in the plan documents, for which a health plan will not provide coverage.

Exclusive Provider Organization (EPO): In an EPO you must use the providers who belong to the EPO or your expenses will not be covered. In other words, you cannot go “outside” the network for medical care.

Explanation of Benefits: A statement sent from the health plan to a plan member listing services that were billed by a health care provider, how those charges were processed, and the total amount of patient financial responsibility for the claim.

External Review: External review is part of the health plan claims denial process. It typically occurs when an independent third party reviews your claim to determine whether the health plan is obligated to pay. External review is one of several steps that comprise the appeal and review

process. It is performed *after* you have exhausted the plan's internal review process without success. It is an appeals review that is conducted by a third party that is not affiliated with the health plan or a providers' association and has no conflict of interest or stake in the outcome of the review.

Financial Requirements: e.g., deductibles, copayments, coinsurance, out-of-pocket maximums that the patient is responsible for paying.

Formulary: A listing of drugs, classified by therapeutic category or disease class, that are considered preferred therapy for a given condition and that are to be used by a Managed Care Organization's providers in prescribing medications.

Fully Insured plan: Employer-based health care coverage purchased through a commercial health plan. These plans are regulated by states. In California, fully-insured plans are regulated either by the California Department of Managed Health Care or the California Department of Insurance, depending on the type of plan.

Affordable Care Act (ACA): A federal law that, among other things, outlines the requirements that employer-sponsored group health plans, health insurance companies, and managed care organizations must satisfy in order to provide healthcare coverage in the individual and group health care markets.

Health Maintenance Organization (HMO): A type of health plan in which you access all or most of your care from a designated network of providers, and you generally go through your Primary Care Physician (PCP) to get referrals to other providers.

Inpatient: A term used to describe a person admitted to a hospital for at least 24 hours, or overnight. It may also be used to describe the care rendered in a hospital when the duration of the stay is at least 24 hours, or overnight.

Managed Behavioral Health Organization (MBHO): A carved-out managed care organization that provides behavioral health services for a health plan.

Medicaid: A joint federal and state program that provides hospital, medical, and other services to certain individuals with limited income, including individuals age 65 and older, and individuals younger than age 65 with certain disabilities. In California, this program is called **Medi-Cal**.

Medically Necessary: Medical services that are essential or required for the diagnosis and/or treatment of a medical condition.

Medicare: A federal government program established under Title XVIII of the Social Security Act to provide hospital and medical insurance to persons who are age 65 or older, or persons younger than age 65 with certain disabilities.

Network: The group of physicians, hospitals, and other medical care professionals that a managed care plan has contracted with to deliver medical services to its members.

Non-Quantitative Treatment Limitation: Any non-financial treatment limitation imposed by a health plan that limits the scope or duration of treatment (i.e. prior authorization, medical necessity, utilization review etc.)

Out-of-Plan/Out-of-Network: Physicians, hospitals, and other health care providers that are not contracted with the health plan to provide health care services at negotiated rates or rates approved by the plan. Depending on an individual's plan, expenses incurred for services provided by out-of plan health care professionals may not be covered, or may be only partially covered.

Outpatient Care: Treatment that is provided to a patient who is able to return home after care without an overnight stay in a hospital or other inpatient facility.

Partial Hospitalization Services: Also referred to as "partial hospital days," this is a health care term used to refer to outpatient services performed in a hospital setting as an alternative or follow-up to inpatient mental health or substance use treatment.

Point-of-Service (POS): Managed care plans that contract with out-of-network providers for certain specialty services that you need are called POS plans.

Prior Authorization: Confirmation of coverage by the health plan for a service or product before you receive the service or product from the health care provider. (Also known as pre-authorization)

Preferred Provider Organization (PPO): A type of health plan where you can access care from a list or network of “preferred” providers, at a lower cost than accessing care from providers outside of that network.

Provider Payment: Amount of money paid to the health care provider by the health plan.

Quantitative Treatment Limitation: Financial requirements such as co-payments, coinsurance, deductibles that must be paid by plan participants.

Reasonable and Customary Fees/Usual and Customary Fees: The average fee charged by a particular type of health care practitioner within a geographic area. These fees are often used by insurers to determine the amount of coverage for health care provided by out-of-network providers. The individual may be responsible for any copayment, coinsurance and deductible, as well as any remaining portion of the provider’s fee that is not covered by the Reasonable and Customary Fee.

Reason Codes: A letter or number system typically presented and defined at the bottom of an Explanation of Benefits (EOB), used to explain how the claim for coverage or payment was processed. These codes are very important in understanding why the health plan denied all or part of your claim.

Self-insured plan (ERISA): A plan offered by employers or unions who directly assume the major cost of health care for their employees or members. Self-insured employee health benefit plans are exempt from many state laws and instead are subject to federal (ERISA) law.

Summary Plan Description (SPD): A description of the benefits included in your health plan. Under some plans, this type of information is called Evidence of Coverage (EOC).

Treatment Limitations: Limits based on frequency of treatment, number of visits, days of coverage, days in a waiting period.

Note: This list of terms is not intended to be exhaustive. These terms are useful in understanding the parity law and navigating the appeals process.

Helpful Links

California Department of Insurance (CDI) consumer page:

<http://www.insurance.ca.gov/0100-consumers/0020-health-related/>

For information about PPOs, POSs and EPOs or to file a complaint about this kind of plan

California Department of Managed Health Care (DMHC) page on mental health parity.

http://www.dmhc.ca.gov/dmhc_consumer/br/br_mentalhth.aspx

For information about HMOs and Blue Cross of California's PPO and Blue Shield's PPO or to file a complaint about this kind of plan.

Consumer Center for Health Education & Advocacy: <http://www.laszd.org>

Disability Rights California: www.disabilityrightsca.org

Mental Health Advocacy Project: www.lawfoundation.org/mhap.asp

Mental Health Advocacy Services, Inc.: www.mhas-la.org

State Laws Mandating or Regulating Mental Health/Substance Use Disorder Benefits:

<http://www.ncsl.org/IssuesResearch/Health/StateLawsMandatingorRegulatingMentalHealthB/tabid/14352/Default.aspx>

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA): www.samhsa.gov

For information about substance use and mental health generally

Appendix

Below is a list of the resources that are available in this section. These tools are fully customizable for your specific situation.

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Checklist for Keeping Track of Your Appeal

Who to contact regarding a health plan appeal

Who to call:

Where to write:

How soon must I appeal?

How many days will it take to receive a response? (List the response times for each level of review)

1st level

2nd level

Expedited review

(for medical emergencies)

Checklist For My Health Plan Coverage

My health plan coverage is through:

- My employer – check if:
 - My plan is a fully-insured plan; any plan denials are eligible for state external review
 - My plan is a self-funded plan; it is not regulated by state law-- federal parity law applies.
- A policy I bought myself; any plan denials are eligible for state external review
- An association-sponsored policy (such as a trade or educational organization); if it is self-funded, it's not regulated by state law, federal parity law applies.
- Other

My health plan:

- Covers mental health
- Manages mental health benefits directly
- Contracts with an outside entity (e.g. MHBO) to manage the plan's mental health benefits

Plan phone number to call if I have a problem: _____

My primary care physician is: _____

My physician's phone number: _____

My mental health/substance use provider's phone number: _____

I need prior authorization for: _____

I do not need a referral from my primary care physician for:

- Lab and x-ray tests
- Other specialist visits
- Other: _____

My primary care physician can refer me to specialists who:

- Are part of his or her group practice
- Are on the health plan network list
- Are outside of the health plan network *only if there are no similar specialists within the network*
- Are outside of the health plan network

I have reviewed the Exclusions and Limitations section in my Evidence of Coverage or Summary Plan Description. My health plan will not pay for or limits the following mental health/substance use services:

Is my provider in my health plan network?

My plan will cover services at the following hospitals: _____

What should I do if I need care while I am outside of my plan's service area?

For non-urgent care: _____

Phone: _____

In an urgent situation: _____

Phone: _____

In an emergency: _____

Phone: _____

If you have a PPO or POS plan:

If I use in-network providers, I will pay:

___ \$ _____ annual deductible

___ % _____ coinsurance for charges that exceed the deductible

If I use out-of-network providers, I will pay:

___ \$ _____ annual deductible

___ % _____ coinsurance for charges that exceed the deductible

Phone Call Log

Information from your health plan card (or have your health plan card handy):

Plan Name: _____
Member Name: _____
Member Date of Birth: _____
Identification Number: _____
Group Number: _____
Medical Record Number: _____
Effective Date: _____
Customer Service Phone Number: _____

WHY?

Reason for the call: _____
Date of service: _____ Date of denial: _____

WHEN?

Date of call: _____ Time of call: _____

WHO?

Name of the health plan representative: _____
Reference # for the call: _____

WHAT?

My questions (*write down before the call*):

- 1.
- 2.
- 3.

The representative's answers (*write down during the call*):

- 1.
- 2.
- 3.

WHAT IS NEXT?

The representative agreed to (*include any deadlines*):

1.

2.

I agreed to (*include any deadlines*):

1.

2.

WHEN WILL I FOLLOW UP?

I will (*circle one*) call/email/fax/write: _____,
on this date: _____.

Check when added to calendar.

Check when complete.

OTHER NOTES:

Model Appeal Letters

There are two general reasons health plans deny coverage for mental health services. These reasons are:

1. The plan does not cover the specific treatment, service or level of care at all; or
2. The plan imposes stricter standards for getting mental health benefits under the plan than it does for getting non-mental-health benefits under the plan.

If a plan excludes or does not cover a particular mental health treatment, service, or level of care, it can be helpful to include with your appeals letter copies of treatment guidelines or research studies showing why that particular treatment, service or level of care is recommended or effective in treating someone with your condition.

Your provider can help you find this information if you are having a problem locating anything, or you can go to www.google.com and search by typing the name or a brief description of the treatment or service in the search bar. Another good resource for this type of information is www.guideline.gov.

The following is the most important element to be included in any appeals letter: The requested treatment or service MUST be tailored to the individual patient's clinical need(s) as documented in the case/medical record. Therefore, it is essential that your mental health care provider provide a clinical justification in the letter (or in a separate letter or report) in support of the recommended treatment, item or service. If you are filing an appeal, your provider can help you with this. Usually a letter from your provider of not more than a page or two is enough. The letter needs to contain enough information so that anyone reading the letter will have enough information to make an independent evaluation of your need for the treatment or service. The letter should contain information about your:

1. Diagnosis
2. Functional limitations (i.e., how the mental health condition affects you)
3. Treatment history and treatment plan (including any medications you take together with the dosage and frequency)
4. Prognosis (i.e., the progress you expect to make)

Denial of Coverage for a Specific Mental Health Service or Treatment

Overview

Because individuals who need mental health treatment or services have a legal right to parity in mental health coverage under the Mental Health Parity Act, we also recommend that you include the legal justification as to why the service or treatment is required under the law. The sample letters and legal analyses in this toolkit will guide you in providing that justification to the health plan. Remember, these materials are just a model for you to use. You will need to tailor them to your specific situation.

This sample letter would be good for any of the following denied claims:

1. Residential treatment for psychiatric disorders;
2. Intermediate levels of care such as intensive outpatient treatment, psychosocial rehabilitation, and assertive community treatment; and
3. Office-based diagnostic and treatment interventions for serious mental health conditions such as psychological testing for diagnostic assessments, standardized tests like the PHQ 9, or other treatment services like individual or group psychotherapy.

Sample model appeal letter for denial of coverage for mental health services or level of care

[Insert Date]

[Insert Name]

[Insert Company Name/Plan]

[Insert Address]

Re: [Insert Patient's name, Patient's health plan, Patient's health plan ID Number and Patient's health plan Group Number]

Dear [Name of contact at health plan]:

I am writing to appeal [plan name]'s decision to deny coverage for [state the name of the specific treatment service denied]. It is my understanding based on your letter of denial dated [insert date of denial] that this [treatment or service] has been denied because:

[Quote the specific reason given in the denial letter].

I have been a member of your plan since [date]. My [insert name of clinician] believes that the best care for me at this time would be [state treatment or service here].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications and the legal justification for why I am entitled to this service under the California Mental Health Parity Act. I have been diagnosed with [mental health diagnosis], which is considered a "severe mental illness" or "severe emotional disturbance of a child" under the California Mental Health Parity Act.

Should you require additional information, please do not hesitate to contact me at [phone number]. I look forward to hearing from you in the near future.

Sincerely,
[Insert your name]

Cc: [insert patient's name]

Enclosure: Disability Rights California Legal Analysis
[Clinical guidelines where appropriate]

Legal Opinion on Denial of Coverage for a Specific Type of Mental Health Service or Treatment

A plan refuses to reimburse for a type or level of care for a serious mental health condition because it claims that there is no requirement under mental health parity laws to cover the particular treatment or service (i.e. no scope of service parity requirement within a benefit classification or across benefit classifications). Examples include:

- 1. Residential treatment for psychiatric disorders;*
 - 2. Intermediate levels of care such as intensive outpatient treatment, psychosocial rehabilitation, or assertive community treatment; or*
 - 3. Office-based diagnostic and treatment interventions for serious mental health conditions such as psychological testing for diagnostic assessments, standardized tests like the PHQ 9, or other treatment services like psychotherapy.*
-

The California Mental Health Parity Act (MHPA), as codified in California Health and Safety Code (Cal. Health & Safety Code) § 1374.72 and California Insurance Code (Cal. Ins. Code) § 10144.5 requires state-regulated health plans to provide medically necessary services to treat severe mental illnesses and childhood severe emotional disturbances. For the purpose of the Parity Act, “severe mental illnesses” include the following list of nine disorders: schizophrenia; schizoaffective disorder; bipolar disorder; major depressive disorders; panic disorder; obsessive-compulsive disorder; pervasive developmental disorder or autism; anorexia nervosa; and bulimia nervosa. Cal. Health & Safety Code § 1374.72(d); Cal. Ins. Code § 10144.5(d). The Parity Act defines a “severe emotional disturbance of a child” more broadly to include any disorder in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance abuse disorder or developmental disorder. Cal. Health & Safety Code § 1374.72(e), Cal. Ins. Code § 10144.5(e). The “severe emotional disturbance” must result in substantial impairment in two or more categories, and inappropriate behavior according to developmental norms. Cal. Health & Safety Code § 1374.72(e), Cal Ins. Code § 10144.5 (e).

The Parity Act requires parity between the mental health and non-mental health benefit within each of the following four classifications: 1. Outpatient services; 2. Inpatient hospital services; 3. Partial hospital services; and 4. Prescription drugs, if the plan covers prescription drugs. Cal. Health & Safety Code §1374.72(b), Cal. Ins. Code § 10144.5(b). The health plans must provide equal benefits for both the medical/surgical benefits and the mental health benefits within these classifications. Equal benefits are not defined as a one-to-one comparison of benefits, but a requirement to provide the same quality of care. *Rea v. Blue Shield of California*, 226 Cal. App. 4th 1209, 1238, 172 Cal. Rptr. 3d 823, 845 (2014). (“...parity instead requires treatment of mental illnesses sufficient to reach the same quality of care afforded physical illnesses.”)

The California Mental Health Parity Act makes clear that health plans are to cover medically necessary treatment for severe mental illnesses and severe emotional disturbances under the same terms and conditions applied to other medical conditions. Cal. Health & Safety Code § 1374.72(a), Cal. Ins. Code § 10144.5(a). Although the Parity Act does not address specific treatments, case law requires health plans to cover all medically necessary mental health treatments. *Harlick v. Blue Shield of California*, 686 F.3d 699, 719 (2012) (“...plans within the scope of the Act must provide coverage of *all* “medically necessary treatment” for “severe mental illnesses” under the same financial terms as those applied to physical illnesses.” *emphasis added*); *Rea v. Blue Shield of California*, 226 Cal. App. 4th 1209, 172 Cal. Rptr. 3d 823; *Burton v. Blue Shield of California Life & Health Ins. Co.*, 2012 WL 242841 (C.D.Cal. Jan 12, 2012).

This means that if a plan provides residential/rehabilitative treatment for a medical/surgical condition, the plan must provide residential/rehabilitative treatment for severe mental illness or severe emotional disturbance as well. The plan cannot place restrictions or limitations on the mental health benefit that it does not also place on the medical/surgical benefit. For example, a plan could not limit mental health residential/rehabilitative treatment to 7 days if it did not also limit medical/surgical residential/rehabilitative treatment to 7 days as well.

In addition, a plan cannot deny so-called “intermediate” mental health/emotional disturbance levels of care on the grounds that there is no equivalent medical/surgical level of care. If the plan’s medical/surgical benefit covers the field of inpatient and ambulatory care, the plan must

cover the field of inpatient and ambulatory mental health care as well, including any “intermediate” services such as intensive outpatient treatment, psychosocial rehabilitation, or assertive community treatment.

Finally, a plan cannot exclude coverage for office-based diagnostic and treatment interventions for serious mental health conditions such as psychological testing for diagnostic assessments, standardized tests like the PHQ 9, or other treatment services like psychotherapy because the plan does not exclude office-based diagnostic and treatment interventions, including assessments and tests, for medical/surgical benefits. If the plan includes these interventions for medical/surgical benefits, it must include them for mental health/emotional disturbance benefits as well.

Denial of a Benefit or Service Based on an Overly-Restrictive Prior Authorization Requirement

Overview

Prior authorization or pre-approval techniques are often used by health plans to control costs by avoiding unnecessary treatment before the treatment takes place. However, when used improperly, this technique can delay or limit your access to care. While there are some treatments under non-mental-health medical care that commonly require prior approval (i.e., physical therapy), mental health is often disproportionately subject to this requirement. The California Mental Health Parity Act requires health plans to provide coverage for all “medically necessary” treatment of a mental health condition within the same terms and conditions as medical treatment. While there are certainly some medical treatments that always require prior authorization before a service has been provided (i.e. physical therapy), the health plan may not apply the rule in a manner that would deny the treatment or service when needed. If prior authorization requirements are applied to only a few medical benefits and virtually all mental health benefits, then the plan has failed to meet the same terms and conditions requirement in the law and would be non-compliant if this makes it substantially more difficult to obtain mental health benefits as compared to other benefits.

[Insert Date]

[Insert Name]

[Insert Company Name/Plan]

[Insert Address]

Re: [Insert Patient’s name, Patient’s health plan, Patient’s health plan ID Number and Patient’s health plan Group Number]

Dear [Name of contact at health plan]:

I am writing to appeal [health plan name]’s decision to deny coverage for [state the name of the specific treatment service denied]. It is my understanding based on your letter of denial dated [insert date of denial] that this [treatment or service] has been denied because:

[Quote the specific reason given in the denial letter].

I have been a member of your plan since [date]. My [insert name of clinician] believes that the best care for me at this time would be [state treatment or service here].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications and the legal justification for why I am entitled to this service under the Mental Health Parity Act. I have been diagnosed with [mental health diagnosis], which is considered a “severe mental illness” or “severe emotional disturbance of a child” under the California Mental Health Parity Act.

Should you require additional information, please do not hesitate to contact me at [phone number]. I look forward to hearing from you in the near future.

Sincerely,
[Insert your name]

Cc: [insert patient’s name]

Enclosure: Disability Rights California Legal Analysis
[Clinical guidelines where appropriate]

Legal Opinion on Denial of a Benefit or Service Based on an Overly-Restrictive Prior Authorization Requirement

Prior authorization or pre-approval techniques are often used by health plans to control costs by avoiding unnecessary treatment before the treatment takes place. However, when used improperly, this technique can delay or limit access to care. While there are some treatments under non-mental-health medical care that commonly require prior approval (i.e., physical therapy), mental health is often disproportionately subject to this requirement. The California Mental Health Parity Act requires health plans to provide coverage for all “medically necessary” treatment of a mental health condition within the same terms and conditions as medical treatment. This means that while health plans can require prior authorization for certain services the health plan may not apply the rule in a manner that disproportionately affects mental health treatment or services, or that would deny mental health treatment or services when needed. If prior authorization requirements are applied to only a few medical benefits and virtually all mental health benefits, then the plan has failed to meet the same terms and conditions requirement in the law and would be non-compliant if this makes it substantially more difficult to obtain mental health benefits as compared to other benefits.

The California Mental Health Parity Act, as codified in California Health and Safety Code (Cal. Health & Safety Code) § 1374.72 and California Insurance Code (Cal. Ins. Code) § 10144.5 requires state-regulated health plans and health insurance policies (collectively referred to as “health plans”) to provide medically necessary services to treat severe mental illnesses and childhood severe emotional disturbances. For the purpose of the Parity Act, “severe mental illnesses” include the following list of nine disorders: schizophrenia; schizoaffective disorder; bipolar disorder; major depressive disorders; panic disorder; obsessive-compulsive disorder; pervasive developmental disorder or autism; anorexia nervosa; and bulimia nervosa. Cal. Health & Safety Code § 1374.72(d); Cal. Ins. Code § 10144.5(d). The Parity Act defines a “severe emotional disturbance of a child” more broadly to include any disorder in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance abuse disorder or developmental disorder. Cal. Health & Safety Code § 1374.72(e); Cal. Ins. Code § 10144.5(e). The “severe emotional disturbance” results in substantial impairment in two or more categories,

and inappropriate behavior according to developmental norms. Cal. Health & Safety Code § 1374.72(e); Cal. Ins. Code § 10144.5(e).

When providing these services, the health plans must insure that the coverage is under the same terms and conditions applied to other medical conditions. Cal. Health & Safety Code § 1374.72(a), Cal. Ins. Code § 10144.5(a). These terms and conditions are defined in subparagraph (c) of the law, which states that they “shall be applied equally to all benefits under the plan contract, shall include, *but not limited to*, the following (1) Maximum lifetime benefits; (2) Copayments; (3) Individual and family deductibles. Cal. Health & Safety Code § 1374.72(c) Cal. Ins. Code § 10144.5(c). Though the terms and conditions identified in the statute refer only to financial terms and conditions, the law expressly states the terms and conditions are not limited to those enumerated. Any suggestion of limitation to financial terms and conditions was denied by the Department of Managed Health Care (DMHC) during the notice-and-comment period for the implementing regulation. DMHC expressly rejected the idea of limiting the coverage for mental health services to financial terms and conditions, stating that: “The draft regulation language makes clear that plans cannot limit mental health coverage to anything less than what is medically necessary and on parity with other health coverage provided by the plan.” DMHC Mental Health Parity, Responses to Comments, 1st Comment Period, 8/16-9/30/2002, at 1, *Harlick v. Blue Shield of California*, 686 F.3d 699, 715.

Prior authorization is a condition that is often imposed by health plans, requiring patients to get approval from the plan before they receive a medically necessary service or treatment. If health plan requires a person with a mental health condition to seek prior approval before *any, or for all but a small number of*, mental health service are provided, but does not require the same for a person seeking medical/surgical care, then there is no parity if the requirement makes it substantially more difficult to obtain mental health services as compared to other covered services. As discussed above, an insurer must provide parity in the terms and conditions between mental health and physical health benefits. Cal. Health & Safety Code § 1374.72(c) and Cal. Ins. Code § 10144.5(c) specifically state the enumerated terms and conditions in the law are not exclusive. In adopting parity regulations, DMHC was very clear in stating that “plans cannot limit mental health coverage to anything less than what is medically necessary and on parity with other health coverage provided by the plan.” A health

plan cannot place more restrictive conditions on the receipt of mental health services than it does on the receipt of physical health services. By requiring prior authorization in excess of what is required for physical health services, a plan is placing excessive limitations on mental health coverage and violating the law.

In conclusion, if a health plan requires a subscriber to seek prior authorization for mental health services in excess of the prior authorization requirements for medical/surgical services, the health plan is in violation of the Mental Health Parity Act. The health plan should cover medically necessary services to treat the severe mental illness or severe emotional disturbance without unduly restricting or delaying the treatment or service.

Denial of Case Management Services such as Phone-Based Care Management or Disease Monitoring Technology

Overview

Under the Mental Health Parity Act, plans may not deny claims for phone based case management, disease monitoring technology or other management interventions used in behavioral health, if the plan reimburses for these services for medical conditions. It is important for you to familiarize yourself with what management interventions are covered under the plan's medical benefits and the guidelines or criteria used to justify their use.

Sample model letter for a denial of a claim for management interventions such as phone-based case management and disease monitoring technology.

[Insert Date]

[Insert Name]

[Insert Company Name/Plan]

[Insert Address]

Re: [Insert Patient's name, Patient's health plan, Patient's health plan ID Number and Patient's health plan Group Number]

Dear [Name of contact at health plan]:

I am writing to appeal [health plan name]'s decision to deny coverage for [state the name of the specific treatment service denied]. It is my understanding based on your letter of denial dated [insert date of denial] that this [treatment or service] has been denied because:

[Quote the specific reason given in the denial letter].

I have been a member of your plan since [date]. My [insert name of clinician] believes that the best care for me at this time would be [state treatment or service here].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications and the legal justification for why I am entitled to this service under the California Mental Health Parity Act. I have been diagnosed with [mental health diagnosis], which is considered a “severe mental illness” or “severe emotional disturbance of a child” under the Mental Health Parity Act.

Should you require additional information, please do not hesitate to contact me at [phone number]. I look forward to hearing from you in the near future.

Sincerely,
[Insert your name]

Cc: [insert patient’s name]

Enclosure: Disability Rights California Legal Analysis
[Clinical guidelines where appropriate]

Legal Opinion on Denial of Case Management Services such as Phone-Based Care Management or Disease Monitoring Technology

If a plan approves case management services such as phone-based case management, disease monitoring technology and tests for medical conditions but refuses to reimburse for these same services for the covered serious mental illnesses as defined by the California Mental Health Parity Act, the plan would be in violation of the law.

The California Mental Health Parity Act (MHPA), as codified in California Health and Safety Code (Cal. Health & Safety Code) § 1374.72 and California Insurance Code (Cal. Ins. Code) § 10144.5 requires state-regulated health plans to provide medically necessary services to treat severe mental illnesses and childhood severe emotional disturbances. For the purpose of the Parity Act, “severe mental illnesses” include the following list of nine disorders: schizophrenia; schizoaffective disorder; bipolar disorder; major depressive disorders; panic disorder; obsessive-compulsive disorder; pervasive developmental disorder or autism; anorexia nervosa; and bulimia nervosa. Cal. Health & Safety Code § 1374.72(d); Cal. Ins. Code § 10144.5(d). The Parity Act defines a “severe emotional disturbance of a child” more broadly to include any disorder in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance abuse disorder or developmental disorder. Cal. Health & Safety Code § 1374.72(e), Cal. Ins. Code § 10144.5(e). The “severe emotional disturbance” must result in substantial impairment in two or more categories, and inappropriate behavior according to developmental norms. Cal. Health & Safety Code § 1374.72(e), Cal. Ins. Code § 10144.5(e); Cal. Ins. Code § 10144.5(e).

The Parity Act further stipulates that benefits are to include outpatient services, inpatient services, partial hospital services, and prescription drugs, if the plan covers any prescription drugs. Cal. Health & Safety Code § 1374.72(b); Cal. Ins. Code § 10144.5(b). While case management services are not specified, this listing of benefits is not exhaustive. The implementing regulation for Health & Safety Code section 1374.72 states the Parity Act “shall include, when medically necessary, all health care services required under the Act *including, but not limited to*, basic health care services within the meaning of Health and Safety Code sections 1345(b) and 1367(i), and section 1300.67 of Title 28.” Cal. Code Regs. tit. 28, § 1300.74.72(a). The words “including, but not limited to” indicate that

the items listed in subparagraph (b) of the Parity Act are illustrative, not exclusive. The courts have also affirmed this interpretation of the law. *Harlick v. Blue Shield of California*, 686 F.3d 699 (2012); *Burton v. Blue Shield of California Life & Health Ins. Co.*, 2012 WL 242841 (C.D.Cal. Jan. 12, 2012); *Rea v. Blue Shield of California*, 226 Cal. App. 4th 1209, 172 Cal. Rptr. 3d 823 (2014).

When providing these services, the health plans must insure that the coverage is under the same terms and conditions applied to other medical conditions. Cal. Health & Safety Code § 1374.72(a), Cal. Ins. Code § 10144.5(a). These terms and conditions are defined in subparagraph (c) of the law, which states that they “shall be applied equally to all benefits under the plan contract, shall include, *but not limited to*, the following (1) Maximum lifetime benefits; (2) Copayments; (3) Individual and family deductibles. Cal. Health & Safety Code §1374.72(c), Cal. Ins. Code § 10144.5(c). Though the terms and conditions enumerated in the statute refer to financial terms and conditions, the law expressly states the terms and conditions are not limited to those enumerated. Any suggestion of limitations was denied by the Department of Managed Health Care (DMHC) during the notice-and-comment period for the implementing regulation. DMHC expressly rejected the idea of limiting the coverage for mental health services, stating that: “The draft regulation language makes clear that plans cannot limit mental health coverage to anything less than what is medically necessary and on parity with other health coverage provided by the plan.” DMHC Mental Health Parity, Responses to Comments, 1st Comment Period, 8/16-9/30/2002, at 1 *Harlick v. Blue Shield of California*, 686 F.3d 699, 715.

Case management tools such as phone-based services are a rapidly expanding service that allows the consumer to work collaboratively with their providers. It refers to the planning and coordination of care services appropriate to achieve the consumer’s goals. These tools can include phone-based services and additional testing and diagnostics. As discussed above, an insurer must provide parity in the terms and conditions between mental health and physical health benefits. Cal. Health & Safety Code §1374.72(c) and Cal. Ins. Code § 10144.5(c) specifically state the enumerated terms and conditions in the law are not exclusive. An insurer cannot place more restrictive conditions on the receipt of mental health services than it does on the receipt of physical health services. An insurer cannot offer or support case management tools under their medical

benefits and not provide the same service under their mental health benefits. Denying a patient with a mental illness the opportunity to utilize these tools would be limiting their access to medically necessary treatment.

Denial of Treatment or Service Based on a Step Therapy or “Fail First” Requirement

Overview

Plans frequently deny patients the treatment or service that has been recommended by their clinician if there is a less expensive alternative to the recommended treatment. The plans will only reimburse for the recommendation if the patient has tried the other options first and failed to respond to the treatment. These “fail first” requirements are often placed upon medication, but can also include residential treatment and other services.

Carefully review your health plan to see if fail first requirements are imposed on behavioral health treatments and services, as compared to treatments and services of other medical conditions. If so, an appeal of a denied claim may be in order.

[Insert Date]

[Insert Name]

[Insert Company Name/Plan]

[Insert Address]

Re: [Insert Patient’s name, Patient’s health plan, Patient’s health plan ID Number and Patient’s health plan Group Number]

Dear [Name of contact at health plan]:

I am writing to appeal [health plan name]’s decision to deny coverage for [state the name of the specific treatment service denied]. It is my understanding based on your letter of denial dated [insert date of denial] that this [treatment or service] has been denied because:

[Quote the specific reason given in the denial letter].

I have been a member of your plan since [date]. My [insert name of clinician] believes that the best care for me at this time would be [state treatment or service here].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications and the legal justification for why I am entitled to this service under the California Mental Health Parity. I have been diagnosed with [mental health diagnosis], which is considered a “severe mental illness” or “severe emotional disturbance of a child” under the Mental Health Parity Act.

Should you require additional information, please do not hesitate to contact me at [phone number]. I look forward to hearing from you in the near future.

Sincerely,
[Insert your name]

Cc: [insert patient’s name]

Enclosure: Disability Rights California Legal Analysis
[Clinical guidelines where appropriate]

Legal Opinion on Denial of Treatment or Service Based on a Step Therapy or “Fail First” Requirement

Plans often deny patients the treatment or service that has been recommended by their clinician if there is a less expensive alternative to the recommended treatment. The plans will only reimburse for the recommended treatment if the patient has tried the other options first and failed to respond to the treatment. These “fail first” requirements are often placed upon medication, but can also include residential treatment and other services.

The California Mental Health Parity Act, as codified in California Health and Safety Code (Cal. Health & Safety Code) § 1374.72 and California Insurance Code (Cal. Ins. Code) § 10144.5 requires state-regulated health plans to provide medically necessary services to treat severe mental illnesses and childhood severe emotional disturbances. For the purpose of the Parity Act, “severe mental illnesses” are the following list of nine disorders: schizophrenia; schizoaffective disorder; bipolar disorder; major depressive disorders; panic disorder; obsessive-compulsive disorder; pervasive developmental disorder or autism; anorexia nervosa; and bulimia nervosa. Cal. Health & Safety Code. § 1374.72(d), Cal. Ins. Code § 10144.5(d). The Parity Act defines a “severe emotional disturbance of a child” more broadly to include any disorder in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance abuse disorder or developmental disorder. Cal. Health & Safety Code § 1374.72(e), Cal. Ins. Code § 10144.5(e). The “severe emotional disturbance” results in substantial impairment in two or more categories, and inappropriate behavior according to developmental norms. Cal. Health & Safety Code § 1374.72(e), Cal. Ins. Code § 10144.5(e).

When providing these services, the health plans must insure that the coverage is under the same terms and conditions applied to other medical conditions. Cal. Health & Safety Code § 1374.72(a), Cal. Ins. Code § 10144.5(a). These terms and conditions are defined in subparagraph (c) of the law, which states that they “shall be applied equally to all benefits under the plan contract, shall include, *but not limited to*, the following (1) Maximum lifetime benefits; (2) Copayments; (3) Individual and family deductibles. Cal. Health & Safety Code § 1374.72(c), Cal. Ins. Code § 10144.5(c). Though the terms and conditions identified in the statute

enumerate only financial terms and conditions, the law expressly states the terms and conditions are not limited to those enumerated. Any suggestion of limitations was denied by the Department of Managed Health Care (DMHC) during the notice-and-comment period for the implementing regulation. DMHC expressly rejected the idea of limiting the coverage for mental health services, stating that: “The draft regulation language makes clear that plans cannot limit mental health coverage to anything less than what is medically necessary and on parity with other health coverage provided by the plan.” DMHC Mental Health Parity, Responses to Comments, 1st Comment Period, 8/16-9/30/2002, at 1, *Harlick v. Blue Shield of California*, 686 F.3d 699, 715.

One practice utilized by health plans to manage costs is to require a patient to fail to improve or achieve desired goals at a lower level of treatment or service before the health plan will approve a more intense treatment or service. This practice is called “fail first.” A plan cannot apply the “fail first” policies more restrictively for mental health than for physical health. As discussed above, a plan must provide parity in the terms and conditions between mental health and physical health benefits. Cal. Health & Safety Code § 1374.72(c) and Cal. Ins. Code § 10144.5(c) specifically state the enumerated terms and conditions in the law are not exclusive. In the first set of responses to commentators, DMHC was very clear in their direction that “plans cannot limit mental health coverage to anything less than what is medically necessary and on parity with other health coverage provided by the plan.” An insurer cannot place more restrictive conditions on the receipt of mental health services than it does on the receipt of physical health services. A “fail first” requirement is a condition that many consumers are required to meet before receiving a more intensive treatment or service. However, if the plan requires compliance for mental health care in excess to what is required in medical care, a plan is placing excessive limitations on the mental health insurer and violating the law.

In addition if imposition of the fail first requirement would cause harm to the consumer, the plan cannot impose the requirement at all. If a provider determines that the less intensive, or less expensive, treatment is not likely to be therapeutic and, as a result, the consumer is likely to deteriorate or otherwise have a less desirable response, the treatment recommended by the provider must be provided. For example, if a consumer is responding well to a particular medication, and the provider is concerned that the consumer would not respond as well to other medications, and has good

reason to believe so, the provider's judgment should be accepted by the plan.

Concurrent Review Requirements for Mental Health Services

Overview

Concurrent review is a process of evaluating a service or care during the time it is provided. This is often conducted by nurses who monitor the appropriateness of the care, the setting and the progress of the patient. This review can benefit both the health plan and the covered individual by keeping costs as low as possible and maintaining effectiveness of care. However, if a plan uses concurrent review excessively with the effect of restricting or limiting mental health services inappropriately, the plan is in violation of the Mental Health Parity Act.

Carefully review your plan for treatments or services that are subject to concurrent review. Ask your plan for details about the concurrent review process and what tools are being used to evaluate the care. If the plan requires concurrent review more often for mental health services than for other medical services, or if the details of the concurrent review are more onerous than concurrent review requirements for non-mental-health services, an appeal of a denied claim may be appropriate.

[Insert Date]

[Insert Name]

[Insert Company Name/Plan]

[Insert Address]

Re: [Insert Patient's name, Patient's health plan, Patient's health plan ID Number and Patient's health plan Group Number]

Dear [Name of contact at health plan]:

I am writing to appeal [health plan name]'s decision to deny coverage for [state the name of the specific treatment service denied]. It is my understanding based on your letter of denial dated [insert date of denial] that this [treatment or service] has been denied because:

[Quote the specific reason given in the denial letter].

I have been a member of your plan since [date]. My [insert name of clinician] believes that the best care for me at this time would be [state treatment or service here].

I have enclosed a letter from [name of clinician] explaining why [he/she] recommends [treatment or service], [his/her] qualifications and the legal justification for why I am entitled to this service under the California Mental Health Parity Act. I have been diagnosed with [mental health diagnosis], which is considered a “severe mental illness” or “severe emotional disturbance of a child” under the Mental Health Parity Act.

Should you require additional information, please do not hesitate to contact me at [phone number]. I look forward to hearing from you in the near future.

Sincerely,
[Insert your name]

Cc: [insert patient’s name]

Enclosure: Disability Rights California Legal Analysis
[Clinical guidelines where appropriate]

Legal Opinion Regarding Concurrent Review Requirements

Concurrent review is a process of evaluating a service or care during the time it is provided. This is often conducted by nurses who monitor the appropriateness of the care, the setting and the progress of the patient. This review can benefit both the health plan and the covered individual by keeping costs as low as possible and maintaining effectiveness of care. However, if a plan uses concurrent review excessively with the effect of restricting or limiting mental health services inappropriately, the plan is in violation of the Mental Health Parity Act.

The California Mental Health Parity Act, as codified in California Health and Safety Code (Cal. Health & Safety Code) § 1374.72 and California Insurance Code (Cal. Ins. Code) § 10144.5, requires state-regulated health plans to provide medically necessary services to treat severe mental illnesses and childhood severe emotional disturbances. For the purpose of the Parity Act, “severe mental illnesses” include the following list of nine disorders: schizophrenia; schizoaffective disorder; bipolar disorder; major depressive disorders; panic disorder; obsessive-compulsive disorder; pervasive developmental disorder or autism; anorexia nervosa; and bulimia nervosa. Cal. Health & Safety Code § 1374.72(d), Cal. Ins. Code § 10144.5(d). The Parity Act defines a “severe emotional disturbance of a child” more broadly to include any disorder in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance abuse disorder or developmental disorder. Cal. Health & Safety Code § 1374.72(e), Cal. Ins. Code § 10144.5(e). The “severe emotional disturbance” results in substantial impairment in two or more categories, and inappropriate behavior according to developmental norms. Cal. Health & Safety Code § 1374.72(e), Cal. Ins. Code § 10144.5(e).

When providing these services, the health plans must insure that the coverage is under the same terms and conditions applied to other medical conditions. Cal. Health & Safety Code § 1374.72(a), Cal. Ins. Code § 10144.5(a). These terms and conditions are defined in subparagraph (c) of the Mental Health Parity Act, which states that they “shall be applied equally to all benefits under the plan contract, shall include, *but not limited to*, the following (1) Maximum lifetime benefits; (2) Copayments; (3) Individual and family deductibles. Cal. Health & Safety Code § 1374.72(c), Cal. Ins. Code § 10144.5(c). Though the terms and conditions identified in the statute refer only to financial terms and conditions, the law expressly

states the terms and conditions are not limited to those enumerated. Any suggestion of limitations was denied by the Department of Managed Health Care (DMHC) during the notice-and-comment period for the implementing regulation. DMHC expressly rejected the suggestions by Blue Shield of California limiting the coverage for mental health services, stating that: “The draft regulation language makes clear that plans cannot limit mental health coverage to anything less than what is medically necessary and on parity with other health coverage provided by the plan.” DMHC Mental Health Parity, Responses to Comments, 1st Comment Period, 8/16-9/30/2002, at 1, *Harlick v. Blue Shield of California*, 686 F.3d 699, 715.

One practice utilized by health plans to manage costs is to conduct a concurrent review as the patient is receiving their treatment or service. A concurrent review entails a periodic review, often by a nurse, to evaluate the setting and progress of the patient. As discussed above, a health plan must provide parity in the terms and conditions between mental health and physical health benefits. Cal. Health & Safety Code § 1374.72(c) and Cal. Ins. Code § 10144.5(c) specifically state the enumerated terms and conditions in the law are not exclusive. A plan cannot place more restrictive conditions on the receipt of mental health services than it does on the receipt of physical health services. A concurrent review is often used for a variety of medical services, both mental and physical. However, if the plan requires compliance for mental health care in excess to what is required in medical care, a plan is placing excessive limitations on the mental health insurer and violating the law.