

Making it happen



**HOW TO ACCESS BEHAVIORAL HEALTH
TREATMENT SERVICES FROM PRIVATE HEALTH
INSURANCE FOR INDIVIDUALS WITH AUTISM
SPECTRUM DISORDERS**

A GUIDE FOR PARENTS



**ALTA CALIFORNIA
REGIONAL CENTER**



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Please refer to the Review of Terms section for definitions of terms that are bolded in this booklet.

The regional center's primary role is to coordinate services for clients and their families that will enable clients to lead more independent, fulfilling lives. In carrying out this role, Alta California Regional Center sometimes pays for services, but we also help families identify and access other payment sources for which they are eligible. These may include public programs such as the public school, Medi-Cal and In-Home Supportive Services (IHSS), and private resources such as client trusts and health insurance. The Lanterman Act requires us to seek out these other sources of coverage before we pay for services.

The purpose of this booklet is to describe recent changes in California law related to how you and your family might receive autism services. Perhaps until now you have received autism services for your child such as behavioral health treatment including applied behavior analysis (ABA) through Regional Center and/or the public school system. Now these services may be available through your private health insurance company.

This booklet will:

- Describe some of the changes taking place,
- Give you some information about how to obtain behavioral health treatment services through private health insurance, and
- Outline what to do if you have a problem obtaining behavioral health services.

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WHAT AUTISM SERVICES ARE INCLUDED?

Behavioral health treatment services are provided for people with **Autism Spectrum Disorders** and include such treatment interventions as **applied behavior analysis (ABA)** and other **evidence-based** interventions.

WHO IS AFFECTED BY THE CHANGES?

The changes described here generally apply to families with private health insurance, meaning health insurance you purchase directly or have available to you as a benefit through your employment. This could include a managed care (HMO) plan or Preferred Provider Organization (PPO) plan.

Under the new law, families with private health insurance will obtain needed behavioral health treatment services including ABA through their health insurance plan and not the regional center.

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WHAT IF MY FAMILY/MY CHILD HAS PRIVATE HEALTH INSURANCE AND

MEDI-CAL? It is likely these changes will apply to you. Typically private health insurance is the primary coverage, meaning your private health insurance pays for health care services before Medi-Cal.



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How to

HOW DO I OBTAIN ABA OR OTHER BEHAVIORAL HEALTH TREATMENT SERVICES FOR MY CHILD FROM MY HEALTH INSURANCE PLAN?

- Ask your child's doctor or primary care provider (PCP) for the behavioral health treatment services you believe are appropriate for your child. If the doctor thinks the services are appropriate and/or **medically necessary**, he/she will give you a referral or prescription.
- Take the prescription to the suggested behavioral health treatment services provider.
- Follow the treatment policies and procedures.

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WHAT IF MY CHILD'S DOCTOR OR PCP WILL NOT GRANT A REFERRAL OR PRESCRIPTION FOR BEHAVIORAL HEALTH TREATMENT SERVICES?

If the doctor will not authorize the services you believe are appropriate and/or medically necessary and you are in a managed care (HMO) plan, you may be able to request a second opinion from another doctor or medical provider within the health plan's network.

If you are enrolled in a preferred provider organization (PPO) you will likely be able to choose providers from either within the plan's network or go to an out-of-network provider.

WHAT IF I RECEIVE A DENIAL FOR SERVICES FROM MY HEALTH INSURANCE PLAN?

If you receive a verbal or written denial you may file an appeal with the health insurance plan. An "appeal" is a formal process to disagree with the plan's decision and ask that it be reversed.

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HOW DO I FILE AN APPEAL WITH MY HEALTH

INSURANCE PLAN? You may submit an appeal by contacting your plan's Member Services department.

To call, check your health insurance Member ID card for your plan's 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.

To submit in writing, you may send a letter to the health insurance plan along with any supporting documentation such as medical records that may support your child's case. Generally the plan's mailing address is on your Member ID card or ask a Member Services representative for the address for where to send an appeal.

You may also be able to submit an appeal directly on your health insurance plan's Web site.

HOW LONG DOES THE PRIVATE HEALTH INSURANCE APPEALS

PROCESS TAKE? The health insurance plan typically has thirty (30) days to issue a decision in response to an appeal. 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 Member Services department representative if you think this should apply to your child.

WHAT IF THERE IS A DELAY OR I NEED ADDITIONAL ASSISTANCE?

WHO ELSE CAN HELP ME? If you do not receive a written response within thirty (30) days or the matter is urgent and cannot wait for the appeals process review (such as outlined above) you may contact the state directly for assistance. Your Member ID card should list contact information of the state oversight office for your health insurance plan.

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For managed care (HMO) plans and plans issued by Anthem Blue Cross of California and Blue Shield of California contact the Department of Managed Health Care:

Department of Managed Health Care
California Help Center
980 9th Street, Suite 500
Sacramento, CA 95814
1-888-466-2219
www.dmhc.ca.gov

For most Preferred Provider Organization (PPO) plans contact the California Department of Insurance:

California Department of Insurance
Consumer Communication Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
1-800-927-HELP (4357)
www.insurance.ca.gov

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WHAT IF THE PLAN'S DECISION IS NOT IN

MY FAVOR? If the HMO or PPO plan denies your appeal, the plan may send you information about your right to request an Independent Medical Review (IMR). The IMR process 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 plan. If this option is available to you and you meet the eligibility criteria, it will be mentioned in your denial letter, but do not hesitate to ask about it when you contact your HMO or PPO plan.

The state oversight offices can also provide information about Independent Medical Review.



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WHAT ARE THE REQUIREMENTS FOR BEHAVIORAL HEALTH TREATMENT SERVICES TO BE COVERED?

In order for behavioral health treatment services to be covered by private health insurance they must meet some specific guidelines as outlined under the law.

- The behavioral health treatment intervention must be prescribed by a licensed physician or developed by a licensed psychologist.
- The behavioral health treatment intervention must be provided under a treatment plan administered by either a **qualified autism service provider** or supervised professional or paraprofessional.
- The behavioral health treatment plan includes **measurable goals** over a specific time period.
- The behavioral health treatment plan is not used to provide or pay for respite, day care or educational services.

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WHAT HEALTH CARE SERVICES OTHER THAN BEHAVIORAL HEALTH TREATMENT SERVICES

ARE COVERED? It is likely that your insurance will provide medically necessary health care services for your child with autism spectrum disorder including:

- Physical Therapy
- Occupational therapy
- Speech Therapy

For more information please see ACRC's publication: *Making it Happen: Requesting Coverage from a Health Plan for Speech, Occupational and Physical Therapy for a Child.*

WHAT WILL I BE RESPONSIBLE TO PAY FOR?

The terms of coverage for behavioral health treatment for autism spectrum disorders are the same as for other health conditions as outlined by your **Evidence of Coverage** and may include out-of-pocket cost sharing such as **copayments**, **coinsurance** and **deductibles**.

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Tips for dealing with your health insurance plan

There are a few simple things that you can do to make things go more smoothly when dealing with your health insurance plan.

TIP 1. DON'T ASSUME THE PLAN IS YOUR

ADVERSARY. By and large, HMO and PPO plans are made up of people who try to do right by their members. When initiating a request to the plan, it is usually helpful to begin with courtesy and a positive approach. Do not assume that your request will be denied.

TIP 2. ALWAYS GET THE NAME OF THE PERSON YOU TALK TO ON THE PHONE.

Because you may get different answers from different people in the plan, be sure to write down the name of the representative/s you talk to.

TIP 3. REMEMBER, THE LANTERMAN ACT,

SECTION 4659. This section says that, before the regional center pays for a service, it must “identify and pursue all possible sources of funding...[for the service] including private entities” such as insurance companies. In other words, the regional center becomes the second

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payer for services, after the private health insurance plan. It may be helpful to mention this provision when dealing with people at the plan, particularly if they try to refer you back to the regional center.

TIP 4. FOLLOW THE HEALTH INSURANCE PLAN'S

RULES. Some health insurance plans require members to go through their primary care physician (PCP) or get “preauthorized” to get a referral for behavioral health treatment or specialty care services as may be required to treat autism spectrum disorders. If your plan requires this, be sure to follow the procedure. Sometimes, people go directly to a provider outside of the plan’s network. If you do this, it may complicate your attempt to have the plan pay for the services and/or it may increase the amount of your out-of-pocket costs.

TIP 5. BE PREPARED TO WORK WITH THE

PROVIDER/SPECIALIST THE PLAN PROVIDES. If you are in a managed care (HMO) plan you may be limited to a certain provider network. Although the network

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should include health care professionals who are experts in the treatment of autism spectrum disorders, the network may not include the particular expert that you want to see (for example, a professional about whom you have heard from another parent). It is likely that you will have to accept a health care professional the health plan contracts with, unless you can make a very compelling argument about why the provider you want is more appropriate to treat your child than the ones on the health plan's network.

TIP 6. LEARN ABOUT YOUR PLAN'S APPEAL

PROCESS. HMO and PPO plans have a formal process for members to disagree with a decision and ask for the decision to be reversed. The process is called *appeal*, *reconsideration*, or *grievance*. (In this document we refer to the process as appeal.) If you ask your plan to pay for a service and they deny the request verbally, ask for a denial letter containing the information you need to appeal the decision. You can find information about the appeal process in your Member Handbook or "Evidence of Coverage."

TIP 7. LEARN ABOUT THE STATE'S INDEPENDENT MEDICAL REVIEW PROCESS.

California has a process that you may be eligible to use to request an Independent Medical Review (IMR) of your plan's denial of your claim. This review is conducted by physicians and other medical specialists who are not affiliated with the plans they review. Usually, you would use this process after you have been unsuccessful with the plan's appeal process.

POINTS TO REMEMBER When dealing with your insurance plan, these are some important points to remember:

- **Do** remember the Lanterman Act, Section 4659.
- **Do** follow your health plan's rules when seeking services.
- **Do** ask your doctor or licensed health care professional for the behavioral health treatment services you feel are appropriate for your child.
- **Do** file an appeal if the plan denies your request for services.
- **Do** learn about California's Independent Medical Review program.

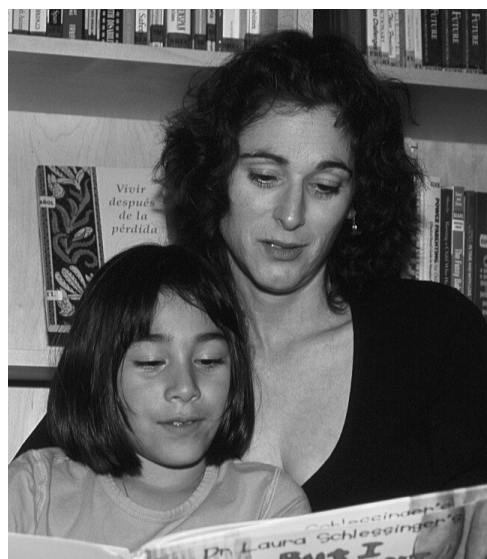
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Behavioral health treatment refers to treatment for mental health conditions. In this context, behavioral health treatment refers to professional services and treatment programs that develop or restore the functioning of an individual with autism spectrum disorder.

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

Applied Behavior Analysis (ABA) 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. ABA is frequently used to address behavioral issues and improve symptoms related to autism.



Evidence-based refers to treatments that scientific research has shown are effective for children who have autism spectrum disorders.

Medically necessary generally refers to health care services that your doctor determines are needed for the diagnosis and/or treatment of your medical or mental health condition.

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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.

Measureable goals refers to standards the provider uses to gauge progress toward the treatment objectives.

The **Evidence of Coverage** or Member Handbook outlines what is covered by your health plan contract and can be obtained from your health plan Member Services.

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

Coinsurance is a percent of the cost of services; you may pay a coinsurance when you see the doctor or obtain a prescription or other health care services.

A **deductible** is the amount you must pay for health care services each year before your health plan or insurance will start to pay.



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