Making it happen

HARBOR REGIONAL CENTER REQUESTING COVERAGE FROM A HEALTH PLAN FOR SPEECH, OCCUPATIONAL AND PHYSICAL THERAPY FOR A CHILD

HARBOR REGIONAL CENTER

Requesting coverage

The California Department of Managed Health Care requires your health plan to provide speech, occupational and physical therapy to your child if it is medically necessary. Your health plan is prohibited from excluding children with a developmental delay or specific diagnoses from receiving these therapies.

This document offers guidance to parents who wish to request coverage under their health plan for speech, occupational or physical therapy for their son or daughter. The information applies to health plans that are regulated by the Department of Managed Health Care (DMHC). These include all Health Maintenance Organizations (HMOs) in California as well as two Preferred Provider Organization (PPO) plans offered by Anthem Blue Cross of California and Blue Shield of California.

WHAT THERAPIES DOES MY HEALTH PLAN COVER?

You can find out what benefits are covered or excluded by your health plan in a document called the Evidence of Coverage, or EOC. You should receive an EOC from your employer or directly from your health plan on an annual basis. If you do not have one, you should request a copy. These documents may also be available on your health plan's Web site.

Health plans are generally required to cover basic health care services that are medically necessary. Since speech, occupational, and physical therapies are basic health care services, they should be covered by your health plan if they are medically necessary for your child.

Until now, many California health plans have specified that these therapies are covered only for the purposes of ***rehabilitation***. Typically, this means that if a health plan member suffers an event such as a stroke or traumatic head injury, these therapies may be provided to return him to his previous level of functioning – i.e., to rehabilitate him. For a child with a developmental delay, the purpose of these therapies is typically not rehabilitative since they would be intended to help the child develop new skills.

The Department of Managed Health Care (DMHC) which regulates a majority of health plans in California has made the decision that health plans will no longer be allowed to categorically exclude speech, occupational, and physical therapies for children or set arbitrary limits on the number of sessions, since these services qualify as basic health care services. The DMHC has instructed health plans to change their Evidence of Coverage (EOC) documents to make it clear that these therapies are available to children *when medically necessary*.

WHAT DOES THIS MEAN FOR ME AND MY CHILD?

If you believe your child needs speech, occupational, or physical therapy you should request an assessment for that therapy from your health plan. The health plan is obligated to do an assessment. If the assessment determines that your child needs therapy, the health plan must provide it. Once services have begun, however, the health plan may periodically evaluate your child's progress in therapy to see if continuation is warranted – in other words, to determine if the services continue to be

medically necessary. (This is referred to by health plans as a "utilization review" process).

WHAT SHOULD I DO IF MY HEALTH PLAN REFUSES?

If you request speech, occupational, or physical therapy for your child and the health plan refuses to provide it, you should appeal that decision with your health plan. Information on how to appeal will be included in the letter that you receive informing you of the health plan's decision not to cover the therapy.

Generally, a health plan must respond to your appeal within 30 days. If they deny your appeal or if you have not received a response to the appeal within 30 days, you may request an Independent Medical Review (IMR) from the Department of Managed Health Care. Information about the IMR process and how to get help is available at **www.healthhelp.ca.gov** or by calling 1-888-466-2219. The letter informing you of the denial of your appeal should also include information about the IMR process.

The Department of Managed Health Care regulates all HMO plans and two PPO plans provided by Anthem Blue Cross of California and Blue Shield of California. If your health plan is a "point of service (POS)," an "exclusive provider organization (EPO)," or a "Preferred Provider Organization (PPO)" other than Anthem Blue Cross of California or Blue Shield of California, it is not regulated by DMHC. Such plans also offer an independent medical review process, but it is provided through the California Department of Insurance. You may call 800-927-4357 or visit their Web site, **www.insurance.ca.gov**.

Some companies "self-insure" to provide health coverage to their employees. (Your human resources department can tell you if you employer is self-insured.) These plans are regulated under federal law (called ERISA), but their rules governing appeals are similar to those described above. They do not, however, have an independent medical review process. Rather, following an unsuccessful appeal, the employee can send all information to:

Employee Benefits Security Administration
Los Angeles Regional Office
1055 East Colorado Blvd., Suite 200
Pasadena, CA 91106-2357
Tel 626.229.1000
Fax 626.229.1098

This office will review the decision to see whether it violates provisions of the benefit plan.

You can find additional information about dealing with your health plan in the Harbor Regional Center booklet, *Obtaining Third Party Health Insurance Coverage for Autism Services: A Parent's Guide*. This document is available in the HRC Resource Center and on the HRC Web site, **www.harborrc.org**, under Publications.

Summary

If you believe your child needs one of these therapies you should:

- Ask your health plan to provide the service to your child. If you are told that the services are not medically necessary, ask for your child to be assessed.
- If the health plan denies your request for an assessment or for the service, you should appeal the denial. Information about how to appeal will be included in the letter informing you of the denial.
- If the health plan denies your appeal or does not respond to your appeal within 30 days, you should request an independent medical review (IMR) from the Department of Managed Health Care. Information about the IMR process will be included in the denial letter. You can also obtain information about the process at **www.healthhelp.ca.gov** or by calling 888-466-2219.
- If the health plan authorizes one of these therapies for your child it may do a periodic assessment of his or her progress to see if the treatment continues to be medically necessary.

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