

# Making it happen



**OBTAINING THIRD PARTY  
HEALTH INSURANCE  
COVERAGE FOR AUTISM  
SERVICES**

**A GUIDE FOR PARENTS**



# Contents

<b>SECTION 1</b>	<b>Introduction</b> .....	1
<b>SECTION 2</b>	<b>A New Law Requiring Coverage for Autism Services</b> .....	2
<b>SECTION 3</b>	<b>Possible Sources for Funding of Autism Services</b> .....	4
	Tips for Dealing with Your Health Plan .....	4
<b>SECTION 4</b>	<b>Requesting Service From Your Health Plan</b> .....	8
	If your plan is an HMO .....	8
	If your Plan is a PPO, Point-of-Service, or	
	Indemnity Plan .....	11
<b>SECTION 5</b>	<b>Points to Remember</b> .....	15

# Introduction

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, the 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 consumer trusts and health insurance. The Lanterman Act requires us to seek out these other sources of coverage before we pay for services.

This booklet is about private health insurance, and it was written expressly for parents of children with autism. It contains information that will make it easier for parents with this type of coverage to get their health plan to pay for certain autism-related services when the use of the third party insurance is appropriate.

## SECTION 1

# A

*new law*

A recent change in California law addresses the responsibility of private health insurance programs to pay for services to treat autistic spectrum disorders. This change came about as a result of Assembly Bill 88 (AB88) that was passed by the California Legislature in 1999 and took effect in January of 2000.

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## SECTION 2

AB88 applies to most health care service plans, including HMOs, PPOs, point-of-service plans, and traditional indemnity plans. (Medicare and Medi-Cal are exempt from this law, as are some plans offered through labor trusts.) The law requires all such plans doing business in California to provide coverage for the diagnosis and treatment of “severe mental illness” as they would for any medical condition. More importantly, AB88 defines severe mental illness to include pervasive developmental disorders: autistic disorder, Rett’s disorder, childhood disintegrative disorder, Asperger’s disorder, and pervasive developmental disorder, not otherwise specified.

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What this means is that most families' medical plans should pay for "medically necessary services" required to diagnose and treat autism spectrum disorders.

Some of the services that may be considered medically necessary are speech therapy, OT, PT, intensive behavior services, and communication devices for non-verbal children.

The requirements of this law mark a significant departure from the way health plans have been operating, and there is still a lot of disagreement about what the law actually means in practice. Because of this, families requesting coverage for services for their children with autism get answers that vary across health plans and, sometimes, even within the same plan. For this reason, we have put together this brochure containing some simple strategies that you can use when requesting services from your health plan. We hope these strategies will make your interaction with the health plan more productive.

## SECTION 2



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## TIPS FOR DEALING WITH YOUR HEALTH PLAN...

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

- **Don't assume the health plan is your adversary.** By and large, health 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.
- **Remember the citation, AB88.** You want the health plan to know that you know that AB88 requires them to provide services for autism spectrum disorders. Keep this bill number in mind and don't hesitate to tell people you communicate with at the health plan that this law is the basis for your request for coverage.

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## SECTION 3

- **Always get the name of the person you talk to on the phone.** Because you may get different answers from different people in the health plan, be sure to write down the name of anyone you talk to.
- **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 payer for services, after the private health plan. It may be helpful to mention this provision when dealing with people at the health plan, particularly if they try to refer you back to the regional center.
- **Follow the health plan’s rules.** Some types of health plans require members to go through their primary care physician or otherwise get “preauthorized” to get a referral for specialty care such as is required to treat autism. If your plan requires this, be sure to follow the procedure. Sometimes, people go directly to a provider outside of the health plan’s network. If you do this, it may greatly complicate your attempt to have the health plan pay for the services or it may increase the amount of your copayment.
- **A health plan must meet your needs.** You may be told that there are no specialists on your health plan’s network who provide the service you are seeking. This is not a sufficient reason for the plan to deny your request for this service. If they don’t have an appropriate provider, they must help you find one and pay him or her for medically necessary care.

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- **Be prepared to work with the specialist the health plan provides.** It is very likely that your health plan will have on its provider network professionals who are experts in the treatment of autism. The network may not, however, include the particular expert that you want to see (for example, a professional about whom you have heard from another parent). You will probably have to accept the professional the health plan offers, unless you can make a very compelling argument about why the provider you want is superior to the ones on the health plan's network.
- **Learn about your health plan's appeal process.** Almost without exception, health 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 health plan to pay for a service and they deny the request, they will send you a denial notice containing the information you need to appeal the decision. You can find information about the appeal process in your Member Handbook or in the document titled "Evidence of Coverage."

- **Learn about the state’s Independent Medical Review Process.** The California Department of Managed Health Care has a process that you may use to request an Independent Medical Review (IMR) of your health plan’s denial of your claim. This review is conducted by physicians and other healthcare professionals who are not affiliated with the health plans they review. Usually, you would use this process after you have been unsuccessful with the health plan’s appeal process.

Information and forms needed to request an Independent Medical Review are available on the web site, [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov) You may also call the Department for information, at (888) HMO-2219. This resource is available to everyone, whether or not their health plan is an HMO. A few plans in California are not covered by the state’s IMR process. Some of these plans have their own independent review process, but some do not. If your plan does not offer access to independent review, you should still call the Department of Managed Health Care. They may be able to help you arrange an independent review.

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# Requesting s

There are slight differences in how you should deal with your health plan, depending on the kind of plan it is. The important distinction is between a health maintenance organization (HMO) that requires you to get a referral from your primary care physician for specialty care, and other plans, such as PPOs, and point-of-service, and indemnity plans, that give you more freedom to access providers on your own.

## 4

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**IF YOUR PLAN IS AN HMO** If you are a member of an HMO or similar plan that requires you to get a referral from your primary care physician (PCP) for specialist services, you should do the following.

- Ask your PCP for a referral for the service you are seeking. Usually a referral must be made to a specialist provider on the HMO's network.
- If you know the doctor or therapist you want to be referred to, find out whether he or she is already on the HMO's provider network. If so, you may ask your PCP to refer you to that provider. If the provider is not on the network,

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you may suggest that he or she apply for membership. Be aware, however, that health plans rarely honor such requests and, if they do, the process can take 6 months or more.

- If you don't have a provider in mind or if the provider you want is not in your plan's network, your physician will make a referral and you will probably need to accept the provider assigned by the HMO.

*Note.* Some HMOs give members direct access to mental health (sometimes called behavioral health) services rather than requiring them to go through their PCP. If your plan is one of these, you should call the direct access number and the customer service representative will give you the name of a provider with whom you can schedule an appointment for an assessment.

- Getting a referral is the first step. The second step is getting the specialist provider to whom you are referred to recommend the services you want.
- If you succeed in getting the referral and getting the specialist to recommend the services you want, you're on your way! If you don't succeed, you will receive a denial notice from the HMO with information about how you can get them to reconsider their decision.
- Follow the instructions in the denial notice. The HMO will send your appeal and the medical information to a reviewer who was not involved in the original denial decision.

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- Many times, people do not appeal denials made by health plans, either because they don't understand the appeal process or because they believe it won't do any good. When people do appeal, the denial is often overturned. They can be overturned as often as 30-40% of the time. So, do not hesitate to file an appeal.
- Generally, health plans are required to complete an appeal and issue a decision within 30 days of receiving the appeal from a member. If a clinical situation is urgent, however, the member may request an "expedited" appeal, which should be completed within 3 – 7 days. Not all requests for expedited appeals are approved.
- If your appeal is denied, you will receive a letter telling you the reason for the denial and giving information about the Independent Medical Review process.

*Note.* Your health plan may have a 2-level appeal process. If it does, the denial letter will give you instructions about how to request a 2nd level appeal before you may seek an Independent Medical Review.

- Submit a request for an Independent Medical Review. Forms are available on the web site, [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov) The statistics on this review process published by the Department of Managed Health Care show that health plans' decisions on medical necessity (your appeal will probably fall in this category) have been overturned about 40% of the time.

- Under rare circumstances, you may request an Independent Medical Review without first going through your health plan's appeal process. The Department of Managed Care prefers, however, that you exhaust the appeal rights in your health plan before requesting an independent review.

#### **IF YOUR PLAN IS A PPO, POINT-OF-SERVICE, OR INDEMNITY PLAN**

If you are covered by a plan that allows you direct access to specialist providers, here is what you should do.

- If you know the doctor or therapist you want to use, find out whether he or she is already affiliated with your health plan. If so, this may allow you to pay a smaller co-payment for the services your child receives. If the provider is not on the network, you may suggest that he or she apply for membership. Be aware, however, that health plans rarely honor such requests and, if they do, the process can take 6 months or more.

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- If you don't have a provider in mind, consult your health plan's Provider Directory or call the customer service number to find the type of specialist you are seeking. If the network has no appropriate providers, you may need to find one yourself.
- If you are seeking help from a non-physician provider (e.g., speech therapist, behavioral psychologist), it is a good idea to ask your primary care physician to write an order for that provider's service. With a physician's order in hand, you will be able to argue more forcefully that the service is "medically necessary." The same is true if you are seeking to purchase medical equipment such as a communication aid.
- Once you have found a provider, make an appointment to talk to him or her about your child's needs.
- Submit a claim after only a few sessions or, better yet, ask the health plan to "preauthorize" the services (tell you in advance whether they will pay for them). Either way, you will know early on whether the health plan will be paying for the services. If the health plan believes that the services are not medically necessary or not a covered benefit, they will either refuse to preauthorize care or deny the claim. They will then send you a denial letter or a document called an "Explanation of Benefits." This document will include information about what to do if you disagree with the decision.

## SECTION 4

- Follow the instructions in the letter or the Explanation of Benefits. The plan will send your appeal and the medical information to a reviewer who was not involved in the original denial decision.
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# Points to

When dealing with your health plan, these are the most important things to remember:

- **Do** remember AB88, the Mental Health Parity law.
- **Do** remember the Lanterman Act, Section 4659.
- **Do** follow your health plan's rules when seeking services.
- **Do not** hesitate to appeal if the health plan denies your request for services.
- **Do** learn about California's Independent Medical Review program and be prepared to use it.

For more general information about your rights as a member of a health plan in California, go to the web site, [www.calpatientguide.org](http://www.calpatientguide.org)

## SECTION 5



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