

Model Appeal Letters

There are some general reasons health plans deny coverage for mental health services, which include:

1. The plan does not consider the treatment medically necessary for you.
2. The plan does not cover the specific treatment, service, or level of care at all.
3. 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 your 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, Including Denials Based on Alleged Lack of Medical Necessity

Overview

Because individuals who need mental health treatment or services have a legal right to parity in mental health coverage under the CMHPA, we recommend you include the legal justification for the service or treatment. The sample letters and legal opinions 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
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 Service or Treatment, Including Denials Based on Alleged Lack of Medical Necessity

[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 Opinion
[Clinical guidelines where appropriate]

Legal Opinion on Denial of Coverage for a Specific Type of Mental Health Service or Treatment, Including Denials Based on Alleged Lack of Medical Necessity

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) or due to an alleged lack of medical necessity.

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 (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” 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).

Health plans subject to the Parity Act must 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 at 719 (“...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 (2014); *Burton v. Blue Shield of California Life & Health Ins. Co.*, 2012 WL 242841 (C.D.Cal. Jan 12, 2012). In making medical necessity determinations for mental health treatments, health plans cannot apply more stringent standards or procedures than they apply to physical health treatments.

If medically necessary, health plans must provide equal benefits for both medical/surgical benefits and mental health benefits. Equal benefits are not defined as a one-to-one comparison of benefits, but a requirement to provide the same quality of care. *Rea*, 226 Cal.App.4th at 1238 (“...parity instead requires treatment of mental illnesses sufficient to reach the same quality of care afforded physical illnesses.”)

The Parity Act requires parity between the mental health and non-mental health benefits within benefit classifications, including outpatient services; inpatient hospital services; partial hospital services; and prescription drugs, if the plan covers prescription drugs. Cal. Health & Safety Code §1374.72(b), Cal. Ins. Code § 10144.5(b). Parity is also required within benefit classifications not enumerated in the statute, such as residential/rehabilitative treatment services. *Harlick*, 686 F.3d at 711, 719; *Rea*, 226 Cal.App.4th at 1231.

This means plans cannot place restrictions or limitations on the mental health benefit that they do not place on any analogous medical/surgical benefit. For example, the Parity Law requires health plans to provide

residential/rehabilitative treatment for severe mental illness or severe emotional disturbance if medically necessary. Health plans must therefore provide mental health residential/rehabilitative treatment services under the same terms and conditions as medical/surgical rehabilitative treatment. For instance, 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.

A plan cannot deny so-called “intermediate” mental health/emotional disturbance levels of care because there is no equivalent medical/surgical level of care. If medically necessary to treat severe mental illness or severe emotional disturbance, plans must cover the field of inpatient and ambulatory mental health care, 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. If medically necessary to diagnose and treat severe mental illness or severe emotional disturbance, these interventions must be covered by the plan.

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 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.

Sample Model Appeal Letter for Denial of a Benefit or Service Based on an Overly-Restrictive Prior Authorization Requirement

[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 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 Opinion
[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 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 (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 ensure 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, and shall include, *but are 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 (9th Cir. 2012).

Prior authorization is a condition often imposed by health plans, requiring patients to get approval from the plan before they receive a medically necessary service or treatment. If a health plan requires a person with a mental health condition to seek prior approval before *all* mental health services, *or for all but a small number of* mental health services, but does not require the same for a person seeking medical/surgical care, then there is no parity.

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 statute are not exclusive. In adopting parity regulations, DMHC stated, “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 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 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 Case Management Services such as Phone-Based Case Management or 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 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 Opinion
[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 violates the law.

The California Mental Health Parity Act (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” 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 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 list 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 affirmed this legal interpretation. *Harlick v. Blue Shield of California*, 686 F.3d 699 (9th Cir.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, health plans must ensure 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 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) (emphasis added).

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 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*, 686 F.3d at 715.

Case management tools, such as phone-based services, are a rapidly expanding service that allows the person to work collaboratively with their providers. It refers to the planning and coordination of care services appropriate to achieve 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 that 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 unlawfully limit 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 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.

Sample Model Appeal Letter for Denial of Treatment or Service Based on a Step Therapy or “Fail First” Requirement

[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 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 Opinion
[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 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 (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, health plans must ensure 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). Terms and conditions are defined in subparagraph (c) of the law, which states that “[t]he terms and conditions...that shall be applied equally to all benefits under the plan contract, shall include, *but not be 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) (emphasis added).

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 (9th Cir. 2012).

One practice used 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 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 stated, “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.

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 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 the consumer would not respond as well to other medications, and has good reason to believe so, the plan should accept the provider's judgment.

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 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 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.

Sample Model Appeal Letter Regarding Concurrent Review Requirements

[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 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 Opinion
[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 Parity Act.

The California Mental Health Parity Act (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 ensure 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 Parity Act, which states that “[t]he terms and conditions...that shall be applied equally to all benefits under the plan contract, shall include, *but not be 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) (emphasis added).

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 699715 (9th Cir. 2012).

One practice used 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 concurrent review 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.