



## *Insurance Coverage for Medically Necessary Therapies*

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. It is also prohibited from arbitrarily limiting the number of therapy sessions that may be provided.

This handout 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.

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 website.

The 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 EOC documents to make it clear that these therapies are available to children *when medically necessary*.

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 plans 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](http://www.healthhelp.ca.gov) or by calling 1-888-466-2219, TDD:1-877-688-9891. The letter informing you of the denial of your appeal should also include information about the IMR process. North Bay Regional Center covers initial assessments for therapies, which can be used in the appeal process to demonstrate a child's need.

If your plan is not one of the plans regulated by DMHC as stated above, it will be regulated by the California Department of Insurance, which also has an independent medical review process. You may call 1-800-927-4357 or visit the California Department of Insurance website, [www.insurance.ca.gov](http://www.insurance.ca.gov).