



Policy Number:	03-13
Policy Name:	Eligibility for Planned (non-emergency) San Mateo County Mental Health Services for Individuals Who Have Private Insurance
Authority:	Divisional; State regulations
Original Policy Date:	April 9, 2003 Effective Date: 04/09/03
Supersedes:	98-06
Policy Last Revised:	N/A
Attachments:	A. Summary Information For Consumers Regarding California’s Mental Health “Parity” Law

PURPOSE

The following policy and procedure is intended to assure that privately insured individuals and individuals eligible to receive services through other treatment systems fully utilize benefits to which they are entitled before they are offered access to the Mental Health Services Division’s publicly funded mental health services that function as a safety net for those who have no other resources.

It is the Mental Health Services Division’s mandate and highest priority to provide mental health services to seriously mentally ill and emotionally disturbed populations that must rely on the public sector for access to treatment. The Division also must provide mental health services identified in the “individual education plans” (IEPs) of children/youth in special education. If these children are privately insured, parent/guardian permission is needed for insurance billing. In addition, the Mental Health Division has a contract with the State Department of Mental Health to provide mental health services to San Mateo County Medi-Cal and seriously emotionally disturbed Healthy Families beneficiaries and with the Health Plan of San Mateo to provide mental health services for their members of the Healthy Families, HealthWorx, and Healthy Kids programs. The Division expects all other individuals with private insurance to obtain mental health treatment through their insurance.

With “parity” for mental health services becoming law in California in July 2000, private health insurers licensed in California are required to diagnose and treat serious mental illness and serious emotional disturbance and to offer the following mental health benefits to seriously mentally ill and emotionally disturbed members: outpatient and inpatient treatment, prescription drugs, and partial hospitalization. In addition, insurers must offer these benefits with the same co-pays, annual maximums, and deductibles as physical health care coverage. The parity law does not require insurance plans to provide mental health benefits to individuals who do not have covered diagnoses of serious mental illness/emotional disturbance. The parity law does not apply to Medicare, vision-only or dental-only insurance plans. Nor does the parity law require insurers to provide the same broad range of mental health services that exists in county mental health systems for individuals with serious



mental illness or emotional disturbance. As a result, under the State's Welfare and Institutions Code, insured individuals who are seriously mentally ill or seriously emotionally disturbed and require services that are not covered under the parity law are among those eligible, within available resources, for county rehabilitative and community support services. This is also the case for individuals who are seriously mentally ill or seriously emotionally disturbed and have exhausted their private insurance benefits (for example, the maximum annual number of inpatient days). The Mental Health Services Division applies its sliding fee scale to these clients to determine financial obligation just as it does to uninsured clients.

The following policy and procedure outlines how the Mental Health Services Division establishes eligibility for mental health services for individuals who have private insurance.

POLICY

- A. The Mental Health Services Division and the contracted agencies whose services it funds should be the providers of last resort for individuals who have private insurance coverage or are eligible to receive mental health services through another treatment system such as the Veteran's Administration or State Parole. Public funds including Medi-Cal are the funding of last resort. Therefore an insured individual will only be considered for treatment in the Division's directly operated and contracted mental health programs if they meet the criteria outlined in the procedure described below.
- B. Psychiatric emergency services and associated Youth Case Management psychiatric emergency-based crisis assessments may be provided to anyone with an emergency psychiatric condition regardless of their insurance coverage. Psychiatric Emergency Services refers insured individuals back to their insurance plan providers after they are stabilized and bills insurance for emergency services provided.

PROCEDURE/PROTOCOL

- A. **Initial contact:** The initial contact to the ACCESS Team or other first point of contact in the Mental Health System should confirm the prospective client's insurance status along with other basic client information. This should occur before the first appointment has been scheduled. If the prospective client has private insurance, he/she should be referred back to their insurance plan for an assessment for mental health services, unless the prospective client is:
 1. A member of an insurance plan with whom Mental Health has a contract to provide services and meets Mental Health medical necessity criteria, including the Health Plan of San Mateo for Healthy Families, Healthworx, Healthy Kids, and the State for seriously emotionally disturbed Healthy Families members. The Mental Health Services Division is the mental health plan for individuals enrolled in these insurance plans and should evaluate these beneficiaries for mental health treatments the Division has contracted to provide using medical necessity criteria.
 2. A child/youth eligible for AB 3632/26.5 mental health services designated on his/her current special education program Individual Educational Plan (IEP).



3. A seriously emotionally disturbed Probation-linked child/youth identified at the Youth Assessment Center or Juvenile Hall.
4. A seriously emotionally disturbed child/youth in the Receiving Home.
5. A foster care or adopted child/youth identified by the Hillcrest Child Welfare Team who has private insurance in addition to Medi-Cal and who meets medical necessity criteria and private insurance benefits or providers are not available or required to cover the necessary service.
6. A seriously mentally ill fee-for-service Medicare/Medi-Cal beneficiary for whom Medicare insurance benefits or providers are not available or required to cover the appropriate service and the Division has the appropriate mental health service available.

Individuals meeting the above exception criteria should be assessed for mental health services assuming they appear to meet clinical and residency criteria based on the phone screening or initial contact and the usual financial evaluation process should be conducted to capture insurance and other billing information so that those resources will be maximized to the extent possible. Individuals in the above categories may have a deductible fee to pay consistent with State client fee guidelines. MH Policy # 03-12 *Client Insurance Information and Financial Participation* describes the financial evaluation process including the method for establishing client fees.

“Parity” benefit for insured clients: All other prospective clients who have private insurance coverage should be referred back to their health plan for an initial assessment for mental health services. Under the parity law, health plans must provide assessment and diagnosis of serious emotional disturbance and serious mental illness for all their members and must provide outpatient/inpatient mental health treatment, prescription drugs and partial hospitalization as medically necessary for those individuals. Attachment A is a summary of mental health services under the parity law and the toll-free phone number of the State oversight agency (and client advocate) that should be distributed to privately insured individuals to assist them in obtaining treatment successfully from their primary insurer.

- B. Subsequent service requests from individuals who were referred back to their insurance:** Some seriously mentally ill adults/emotionally disturbed children and youth will not be successful in obtaining mental health services through their primary insurance, either because: their plan is out of compliance with parity laws; their insurance plan is Medicare or from out-of-state and does not offer parity; their benefits have been exhausted; the service they require, for example long term care, is not covered by the parity law or offered by their plan. If the prospective client is NOT a member of one of the excepted groups 1-6 identified above, and has already tried and failed to obtain mental health treatment through his/her insurance plan, he/she may or may not be eligible for services through the Division of Mental Health. Insured individuals who do not have serious mental illness/serious emotional disturbance are not eligible for Division Mental Health Services. Eligibility depends on whether the prospective client is seriously mentally ill/seriously emotionally disturbed, whether the service required is one that should be covered by insurance under the parity law, and whether the Division offers and has available an appropriate service. The following procedure assists the Division in determining whether or not to admit such individuals to public mental health services:

Before referring such individuals for a mental health assessment for services through the Division of



Mental Health, these individuals (or responsible party) will be asked by the ACCESS Team to provide:

1. A verbal or written account of what happened in their attempt to access services from their own health insurance plan, including a description of what services were requested and what services were not provided. Individuals who have been unsuccessful in obtaining benefits they are likely entitled to under the parity law will be referred to the State contact person (Attachment A) to help them negotiate with their insurance plan.
2. Information that substantiates the prospective client's serious mental illness/serious emotional disturbance; and copies of relevant previous medical records from last treating provider for review by ACCESS Team/other first point of contact. Note: the State's medical necessity criteria applies to beneficiaries who have Medi-Cal in addition to private insurance.
3. A copy of the explanation of benefits (a standard written explanation provided by insurance plans) or other documentation from the insurance plan demonstrating that it either does not provide the service at-issue, benefits have been exhausted, or other explanation.

ACCESS Team staff will review and make an initial determination based on this information and consideration of the Division's available resources if it appears to involve a request for outpatient mental health services. The ACCESS Team will not authorize Division services that the individual should be able to obtain through their insurance under the parity law. (Note: the Mental Health Director or designee must approve any exception to this policy.)

The ACCESS Team will consult with the Adult Resource Management Unit Chief or designee if the referral involves an adult requesting more than outpatient mental health services. The ACCESS Team will consult with the Youth Case Management Unit Chief or designee if the referral involves a child/youth request for more than outpatient mental health services. These requests will be reviewed in light of clinical need and available resources. Services will not be authorized that should be available through the individual's insurance. The ACCESS Team staff will respond to the prospective client/responsible party with the results of the initial determination. Some referrals will require a face-to-face evaluation to make a final determination.

- C. **Clients who obtain private insurance after they are receiving services in the Mental Health system** are expected to report that information to the Division either at the clinic site or to the Billing Office so that their insurance billing information can be updated. Treating clinicians of newly insured clients are expected to assist them transition to utilizing their private insurance benefits and providers to the extent possible, for outpatient, inpatient, partial hospitalization, and medication services. All newly insured individuals (except those in categories 1-6, Section A of this document) should be referred to their insurance plan for a formal mental health assessment to determine what benefits they may receive through their insurance. Unit Chiefs and their staff may use the results of this assessment along with other considerations of this policy to evaluate whether or not newly insured individuals should continue to receive services non-parity covered services through the Division. All decisions to retain newly insured clients in treatment will be reviewed by the Adult or Child/Youth Deputy Director. In some cases, the most appropriate solution will be for insurance and Division providers to share the responsibility for treating the



client. This may be indicated when the insurance benefit only covers part of the appropriate treatment plan.

- D. **Private insurance authorizations to pay for mental health services provided by the Division of Mental Health:** Occasionally a private insurance plan will authorize one of the Division’s providers to deliver mental health services to a plan member. Generally this occurs when a plan cannot provide the service but has determined the service is medically necessary. The Division’s policy is to provide services under these circumstances only to individuals who are seriously mentally ill or seriously emotionally disturbed and fall into the other parameters of this policy and procedure. Any authorizations to pay for treatment should be copied to the client’s chart and forwarded to the Division’s Billing Office. Inquiries from insurance plans regarding development of contracts for Division services should be forwarded to the Deputy Director of Operations.

SIGNATURES

Approved: _____ *Signature on File*
 Gale Bataille, Director
 Mental Health Services Division

REVISION HISTORY

Date of Revision	Type of Revision	Revision Description