What to hand a client whose insurance denied care.

When a California insurer denies mental-health or substance-use treatment as "not medically necessary," a grievance, appeal, or independent review may be available. This handout gives a client a manageable place to begin.

WHY IT MATTERS

The client gets a clearer way to challenge the denial.

The provider can document why the requested care is medically necessary.

Both can keep the supporting facts organized.

WHAT THE CLIENT GETS

1. A free Path Finder (no signup) that selects a likely California path from confirmed answers: grievance, appeal, Independent Medical Review, or regulator.
2. A drafted appeal packet with protections that may apply (SB 855 parity, Health & Safety Code, MHPAEA), automated source checks, and clear prompts for the client to review.
3. A provider template letter to attest medical necessity by recognized standards (LOCUS, CALOCUS-CASII, ASAM, APA, AED). Designed to take about 10 minutes to complete.

Path Finder is free. The complete, exportable packet is free ($0). No subscription.

79% of California mental-health decisions taken to Independent Medical Review favored the member in 2025.

Source: CalHHS / DMHC Independent Medical Review determinations (309 of 389, behavioral-health categories). Historical aggregate, not a prediction for any case.

Mental-health coverage should stand on equal footing with physical-health coverage. The applicable protections depend on the plan and denial.

WHAT TO TELL A CLIENT

"A medical-necessity denial may be challengeable. A free tool uses your confirmed answers to select a likely filing path for you to verify. Start at parity.care."