

How to Seek Out-of-Network Reimbursement for Testing or Therapy Services

Navigating the world of insurance and healthcare can be challenging, especially when it comes to out-of-network benefits. If you're considering or have already received testing or therapy services from a provider who is not within your insurance network, you may be eligible for out-of-network reimbursement.* Here's how you can seek reimbursement for these services:

** The information provided here is for informational purposes only and is not intended to be a substitute for information from your healthcare insurance or professional legal advice. While we strive to ensure the accuracy and reliability of the content, it should not be considered exhaustive or up-to-date with the latest insurance policies or healthcare laws.*

Understand Your Insurance Plan

Before you schedule an appointment, it's important to understand your insurance plan's coverage for out-of-network services. Typically, this information can be found in your plan's Summary Plan Description (SPD) or by contacting your insurance customer service. Make sure to ask about:

- The percentage of the cost covered for out-of-network services
- Any deductibles that must be met
- The process for submitting claims
- Required documentation for reimbursement
- Deadlines for claim submission
- Coverage for Telehealth

Get Pre-Approval if Necessary

Some insurance plans require pre-approval or a referral from a primary care physician before they will consider reimbursement for out-of-network services. Check with your insurance provider to see if this is required and obtain any necessary authorizations prior to receiving services. ***Additional information about the preapproval process can be found at the end of this document.***

Obtain a Superbill from your Provider After Services are Completed

This will include:

- Itemized billing
- Diagnostic codes
- Treatment/billing codes
- Provider's full name and contact information

Note: The Superbill will need to show it has been paid for insurance to consider reimbursement

Submitting Your Claim

To submit a claim for out-of-network reimbursement, follow these steps:

1. **Claim Form:** Obtain a claim form from your insurance company, either by downloading it from their website or by requesting they mail one to you. You may also be able to complete the form online.
2. **Complete the Form:** Fill out the claim form accurately. Provide all requested information, including your personal information, insurance policy number, and details about the services received.
3. **Attach the Superbill.**
4. **Review:** Double-check the form and attachments to ensure all information is complete and accurate.
5. **Submit:** Submit online or send your completed claim form and attachments to the address specified by your insurance provider. This is often done by mail, but some providers may allow electronic submission.
6. **Keep Copies:** Make copies of everything you submit for your own records.

Follow Up

After submitting your claim, mark your calendar to follow up. Insurance companies typically process claims within 30 to 60 days. If you haven't received a response or reimbursement after this time, contact your insurance company to inquire about the status of your claim.

Appeal if Necessary

If your claim is denied or you receive less reimbursement than expected, you have the right to appeal the decision. Review the denial letter for the reason, and if you believe the decision was incorrect, submit an appeal according to your insurance company's guidelines. Provide additional documentation or information that supports your case.

Pre-approval and PPO Waivers

“Pre-approval”, also known as prior authorization, is a decision by your health insurer that a healthcare service, treatment plan, prescription drug, or durable medical equipment is medically necessary. This approval must be granted before you receive the service to qualify for coverage.

A “PPO waiver” is a special permission granted by the insurance company that allows you to receive services from an out-of-network provider at in-network coverage rates, often because an equivalent service is not available within the network.

Steps to Obtain Pre-approval or a PPO Waiver – May vary depending on insurance plan

1. **Verify Your Benefits:** Contact your insurance company to confirm if your plan allows for pre-approval or PPO waivers for out-of-network services. Ask about the specific conditions under which such exceptions are made.
2. **Gather Information:** Before applying for pre-approval or a waiver, collect all necessary information, including:
 - *The specific service or procedure you need.* For example, a diagnostic evaluation for Autism. The insurance provider will ask for specific billing codes (“CPT codes”). The most common codes that Dr. Eaton-Lupas bills are listed below:

Assessment CPT codes:

- **90791** (Intake appointment)
- **96130** and **96131** (Psychological evaluation services, including interpretation, report writing, and feedback appointment)
- **96136** and **96137** (Psychological test administration and scoring)

Therapy CPT codes:

- **90791** (Intake appointment)
- **90832** (Individual therapy, 16-38 minutes)
- **90834** (Individual therapy, 39-52 minutes)
- **90837** (Individual therapy, 53+ minutes)
- **90846** (Parent session *without* child present)
- *The reason why the service must be performed by an out-of-network provider.* This may include the provider's expertise, the quality of care, proximity, or availability. For example, there are long waitlists for this service because there are few clinicians who specialize in ASD evaluations. If the waitlist at the in-network location is long (for example, the waitlist at Seattle Children's is reportedly 3 years), this may help your application.

- *Any relevant medical records* or documentation that supports the necessity of the service
3. **Submit the Request:** Fill out any required forms provided by your insurance company for preapproval or a waiver request.
 4. **Follow Up:** After submitting your request, follow up with your insurance company regularly to check on the status. Keep a record of all communications, including names, dates, and summaries of conversations.
 5. **Receive Decision:** Your insurance company will review the request and make a decision. If approved, you will receive a letter of authorization. Make sure to understand any terms and conditions associated with the approval.
 6. **Schedule Services:** Once you have preapproval or a waiver, you can schedule your service with the out-of-network provider. Ensure that the provider is aware of the preapproval or waiver when billing for services.

Tips for a Smooth Preapproval or Waiver Process

- Start the process as early as possible to allow ample time for review and potential appeals.
- Maintain open communication with both your healthcare provider and your insurance company.
- Be clear and concise in your communications, and always advocate for your or your child's medical needs.
- Understand that some requests may require multiple levels of review before a decision is reached.