Insurance Tips and Information

The Clinic at Virtually Better is not an in-network participating provider for any insurance plans and does not directly bill insurance. Our psychologists are considered "out-of-network" (or "non-network") pro**v**iders, and we cannot guarantee that insurance companies will reimburse any or all expenses for our services.

Current trends in managed care tend to uniformly place restrictions on reimbursement for behavioral health services, regardless of clinical recommendations. For example, scientific evidence suggests some treatments, particularly for moderate to severe symptoms, may be more beneficial when sessions are longer in length (e.g., 60-90 minute exposure sessions or family meetings) and massed (e.g., daily or several times a week) rather than when they are spaced (e.g., weekly). Although our structure for services can actually be more cost-effective in the long run, some insurance coverage may not reimburse for such sessions. It is our intention, focus, and commitment to spend time providing individualized services of the highest quality and confidentiality, while avoiding bureaucratic details or delays in treatment.

Thus, like many specialty behavioral health clinics around the country, we **do not** bill or submit claims directly to insurance companies, and **are not** participating providers for any insurance plans. However, we will provide you with all the necessary documentation required for submitting claims to your insurance carrier on your own should you choose to do so. Some insurance companies will work with their members regarding these treatments, particularly when clinical necessity indicates a need for anxiety specialty treatment (e.g., OCD, Phobias, PTSD). We will gladly provide brief summaries of the recommended evidenced based treatments and clinical rationale for our treatment plans. While many patients are successful in seeking reimbursement for at least a portion of their therapy fees, please remember that **reimbursement is considered a matter between you and your insurance company.** Always check with them directly for questions about your coverage.

If you choose to use your insurance, it is your responsibility to contact your carrier prior to beginning treatment to understand your policy coverage and procedures for obtaining any reimbursement. There are some service fees that are rarely reimbursed regardless of plan, such as travel fees, late charges, extensive phone consultations, or cancellation charges.

Documentation Needs

We are happy to provide a brief (i.e., up to one page) summary for your insurance company as part of your assessment at no additional cost. This will outline any formal diagnosis and our proposed recommendations for treatment. We are also available to speak by phone with an insurance representative for a pre-approval process. This summary and/or phone contact needs to be requested before or during the first 4 weeks following your original assessment appointment to be considered part of the evaluation package service fee. Any requested documentation outside of this initial process (e.g., communications during appeals) will be handled per our usual policies for letters and communications and billed pro-rated at your clinician's usual rate.

Recommendations on getting the most out of your insurance

We strongly recommend checking with your health insurance carrier and your employers' benefits coordinator before coming in for your first appointment so that you can be best prepared. You may have benefits under your general health insurance coverage, or under a so-called "Employee Assistance Program (EAP)." Check directly with your insurance plan providers regarding your out-of-network coverage for "Behavioral Health" or "Mental Health" and get the answer to the following questions:

- *Is my coverage an HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization)?*
  PPO benefits typically allow greater flexibility and at least some level of reimbursement for out-of network providers. However, many companies have recently been increasing restrictions for every type of plan.
- *What are the company's guidelines and procedures for pursuing a "Single Case Exception"?*
  Depending on your clinical situation and policy restrictions, your needs may qualify for accommodations that would provide you with higher, in-network levels of coverage reimbursement. Please discuss the insurance information you obtain with your psychologists to help determine if this might be an appropriate avenue to pursue for your situation. We have been successful at working with several insurance companies to get approval for "Single Case Agreements," particularly when Exposure Therapy for an anxiety disorder is recommended, as we are one of only a handful of clinics in Atlanta that specialize in providing similar specific services. However, this requires you, the patient, to initiate and be proactive with your insurer.
- *At what "usual and customary" rates will your policy reimburse you for"?*
  "Usual and customary" (U&C) refers to the allowable charge an insurance company will consider for different services. Companies often reimburse at a percentile or percentage of your plan's U&C and not billed charges. U&C rates are often extremely low and are not what treatment actually costs. These rates may be calculated by your carrier in a variety of ways, often an average of all providers using the same code in a given region, which will not reflect the variations in charges such as training, experience, and more specific factors of the type of treatment.
- *Are there CPT codes (Current Procedural Terminology) or other rules about what the company does not pay for?*
  CPT codes are used to indicate the type of service provided, and companies vary in terms of which codes they will reimburse for. Often, insurance companies will designate their own internal policies for covered codes or service restrictions. Our legal responsibility as providers is to code the most accurate description of the delivered service from current published codes.

The most common codes we will use are as follows:

PLEASE NOTE: THESE ARE UPDATED AS OF REQUIRED CPT CHANGES EFFECTIVE JANUARY 1, 2013.

90791 Diagnostic Evaluation
(A flat fee is charged for the entire assessment package that includes your first 60-120 appointments, review of records and packet of New Patient information, including some standardized questionnaire assessments)

Therapy sessions, consult meetings, and phone calls are billed by professional time, pro-rated in 10-minute increments at that clinician's fee, according to the following codes. Any time for travel charges (outside of therapy time) is charged at 50% of our normal rates.

90832 30 minute therapy (indicated for range of 16-37 minutes)

90834 45 minute therapy (range of 38-52 minutes)

90837 60 minute therapy (range of 53+minutes)

99354 Extended Session - This is a companion code (billed along with the 90837 code) that indicates a session duration greater than that accounted for by CPT 90837 (common with exposure therapy sessions).

Because we provide individually tailored programs, exact charges for a treatment depend on the amount of time each individual requires and will vary from patient to patient.

We do not bill for time not used (e.g., if a session wraps up early), and we adjust our protocol as treatment progresses (to more or fewer sessions, or shorter or longer sessions) depending on your response.

Our evaluation process helps us to estimate what we believe would be the least expensive but most effective treatment plan for each person, but we can't assess each person's response to the treatment until we get started. Having provided these services for over 15 years, our clinic knows that there are simply individual responses to therapy that are not necessarily tied to symptom severity (e.g., there are times mild symptoms take longer than anticipated, while others with more severe symptoms can go much faster than originally thought). We always continue to assess and monitor, and will openly suggest alternative or adjunct referral options to consider if we believe them to be in the best interest of clinical need and cost effectiveness.