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Insurance Questions A to Z: Part 1 (A-H)

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PPA's Insurance Committee[1] has identified some common questions that arise in billing for services. In this article, we offer answers to many common questions in a more-or-less A to Z glossary format. Of course, insurance laws and procedures are always changing. Consequently, readers should keep abreast of changes by reading the *Pennsylvania Psychologist,* as well as announcements and publications from the various insurance companies.

A: Assignment Accounts

This is an agreement with a payor (insurance company) under which the insurer pays claims to a group or employer instead of directly to the provider. The group is considered to bear most of the liability for the claim.

A: Authorization

Some insurance companies require authorization for outpatient psychotherapy services, but almost always for inpatient or partial hospitalization. Insurers may require authorizations for all services, or only for certain services such as 90837, autism services, or for services that exceed a set number of sessions. Check with the insurance company for limits on services and authorization requirements.

A: Automobile Insurance

Automobile insurance policies in Pennsylvania must cover up to $5,000 of medical expenses related to a car accident. Patients may get more coverage for medical expenses as part of their automobile policies, but few do. For most patients, the first $5,000 is used up quickly with emergency room and other initial medical expenses after which the patient's regular health insurance covers costs. However, some patients will seek out mental health services without having depleted the automobile insurance health benefit. If that is the case, then state law prohibits psychologists and other health care professionals from charging more than 110% of Medicare's rate. Sometimes a regular health insurance company will manage the health insurance offered by the automobile insurance policy. Consequently, psychologists who hold in-network contracts with that health insurer may be committed to accepting a lower rate if found in the provider contract. The services must be related to the automobile accident. The insurers may require notes as a condition of paying for services. Good notes will document the relationship of the services to the accident.

After patients have exhausted the medical expenses portion of the automobile policy, the providers will typically bill the patient's health insurance policy for continuing service. The provider should indicate on the claim form that the expense is related to an automobile accident. In most cases, the health insurance company will first verify that the patient has exhausted the automobile

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1. Dr. Knapp, Dr. Schur, and Ms. Baturin thank the members of PPA's Insurance Committee who also contributed to these articles.

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health benefits and then pay the claim, so there may be a delay in getting paid.

When patients are involved in lawsuits related to the automobile accident, attorneys sometimes request that the providers defer billing the patient until the lawsuit is resolved. This is generally not a good idea. It may put the psychologist in the questionable position of having a stake in the outcome of the lawsuit. When the lawsuit is resolved, the patients or their attorneys may simply refuse to pay the psychologist, even if they win the lawsuit. Consequently, psychologists must decide whether to accept the loss or take legal action against their former patient.

B: Benefit Coordination

When two or more health insurance policies cover a single patient, the different insurers will coordinate among themselves to determine which one will pay for the services first, and which one will pay for any remaining costs covered by their policy. Through a set of rules established by insurance laws, one plan will be designated as primary and the other as a secondary plan (there may also be tertiary plans in highly unusual circumstances). For example, when a patient is covered by both a commercial plan and Medicaid, the commercial plan will always be the primary insurer. Medicare has more complicated rules. Medicare could either be primary or secondary. Medicare's Audio Response Unit (ARU) will tell providers whether Medicare is primary or secondary for a given patient. Psychologists can call the number on any Medicare Explanation of Benefits (EOB; 877-235-8973) and follow the prompts to check eligibility. When Medicare is secondary it can be used to cover copay amounts from the patients' primary insurance. Novitas, Medicare's intermediary in Pennsylvania, has a special form on its website that must be filed with this claim.

When a patient has coverage through their own health insurance or health insurance from the employer of a spouse, that insurance will usually be primary. When a child is covered by health insurance from both parents, there are rules that determine which is primary. Sometimes insurers use the *birthday rule*. In that case, the child is covered by the parent whose birthday falls first in the calendar year. Psychologists should check with both insurance companies to be certain that they are billing properly.

C: Council on Affordable Quality Health Care (CAQH)

The CAQH offers a credentialing service that is used by many, but not all, health care insurers. Using the CAQH is time consuming at first, but may save providers time in the long run when updating their credentials with health care insurers.

C: Children's Health Insurance Program (CHIP)

This combined state and federal program offers health insurance to children under the age of 19 whose parents make too much for Medicaid, but too little to purchase commercial health insurance. The commercial health insurers that administer the program vary from county to county.

When a child is covered by health insurance from both parents, there are rules that determine which is primary. Sometimes insurers use the birthday rule. *In that case, the child is covered by the parent whose birthday falls first in the calendar year.*

C: Clean Claims

Pennsylvania's Act 68 requires insurers regulated by the Pennsylvania Insurance Department to pay all clean claims within 45 days or pay the provider a small penalty fee. Providers must also attempt to resolve the issue informally before contacting the Insurance Department. Our experience has been that the most common reason for delay in payment involves a claim that is not clean. The major limitation of Act 68 is that it is a state law that only applies to insurance companies or contracts regulated by state law, which is about 40% of commercial insurers.

C: CMS (Centers for Medicare and Medicaid Services)

CMS is the Federal agency that regulates and manages these programs. Commercial insurers may, but do not have to, adopt CMS policies.

C: CMS-1500

The standardized form for filing claims with Medicare, Medicaid, and Medical Assistance.

C: Coinsurance vs. Copayment

Both these terms refer to the amounts that patients must pay to their provider as partial payment for services covered by insurance. Coinsurance generally refers to a percentage of the insurance company's allowance for a given service. For example, the insurance company may pay 80% of its allowed charge for a given service, while the patient is expected to pay 20%.

Copayment usually refers to a patient payment of a fixed amount for a given service. For example, if a patient has a copay of $25, then the patient will pay $25 for each psychotherapy service, whether the session is billed as a 90832, 90834, or 90837.

C: Complexity Codes

Health care professionals can use a complexity code (90875) to get a modest increase in reimbursement for a session involving either (a) the use of play equipment for patients who lack fluency or have underdeveloped verbal skills; (b) when parents with discordant views complicate treatment; or (c) when there is a mandated reporting situation such as allegations of childhood abuse. 90875 can be combined with 90871, 90832, 90834, 90837, 90838 or 90853.

C: CPT (Current Procedural Terminology)

The standardized set of codes describing medical and related procedures published by the American Medical Association. These codes change periodically, with minor changes being published at least annually.

C: Credentialed v. Contracted Plans

To be credentialed with an insurance company is to have that company review a provider's educational background, experience, and license status, and then agree that the provider meets the company's criteria to provide services to its subscribers. To be contracted with an insurance company is to have an agreement that the insurance company will pay the provider for the services

provided when those services meet the conditions of the insurance company.

If a psychologist is hired, for example, by a group practice, the psychologist will have to go through the process of being credentialed by each insurance company before the group practice can bill for psychological services. If a psychologist leaves the group practice to go to another group practice, the psychologist remains credentialed and does not have to the repeat the process at the new group practice. However, if the psychologist leaves the group practice to establish a new practice, the insurance company will not pay the psychologist as an in-network provider unless the psychologist has signed a contract with the insurance company. So, a psychologist can be credentialed with an insurance company and not be contracted, and therefore will not be paid as an in-network provider. Credentialing is portable, contracts are not.

C: Crisis Codes (90839, 90840)

CPT Code 90839 can be used for crisis services involving psychotherapy, mobilization of resources, or interventions used to mitigate the potential for psychological trauma. Typically, it involves life endangering qualities and great psychological distress. It can range from 30- to 74- minutes. In addition, psychologists can add 90840 for every additional 30 minutes of service beyond the first 74 minutes. Some insurers require pre-authorization to bill for crisis codes. Psychologists should check with their insurance companies.

D: Debt and Debt Collection

Perhaps the most frustrating experience of psychologists in independent practice is when patients accrue debts and fail to pay. Psychologists can take three steps to reduce the likelihood that patients will acquire bad debts.

1. Always verify the patient's insurance information up front and have them sign an agreement that they are financially responsible if the insurance companies do not pay. This is consistent with the requirements of the Standard 6.04 (a) of the APA Ethics Code which states that "as early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements."
2. Collect all fees at the time of service, including all deductible charges.
3. Use credit cards (or devices such as Google Square) and keep the patient's card on file to charge the patient portion of the fee if the patient does not pay with cash or check.

Perhaps the most frustrating experience of psychologists in independent practice is when patients accrue debts and fail to pay.

Whether a psychologist should use a collection agency or go to small claims courts is an individual decision. Some psychologists believe strongly in pursuing all bad debts on principle; others are more pragmatic. The APA Ethics Code states that "psychologists will inform the person that such measures will be taken and provide that person an opportunity to make prompt payment" (Standard 6.04 (c)). The Ethics Code does not specify how much time should be given, but 30 days seems adequate.

Nonetheless, back end techniques (small claims court or bill collection agencies) may require a lot of effort and risks generating ill feeling or even precipitating a licensing board complaint. Furthermore, even winning a case in small claims court does not necessarily guarantee that the patient will pay the debt. At times, prudent psychologists will cut their losses, forget about the debt, and move on. The best strategy, however, is not to let debts accrue at all.

D: Diagnoses Not Covered

All covered health care services must have a diagnosis within the International Classification of Disease (ICD). Health insurance companies reserve the right to exclude certain diagnoses. Typically, they exclude diagnoses that involve intellectual capacity (dealing with intellectual disability, for example), personality disorders, or dementia. They will however, cover patients with personality disorders or dementias if the patients have additional covered diagnoses. Other exclusions may be idiosyncratic to the insurer. Attention-deficit disorder is commonly excluded from insurance contracts. Some insurance companies do not pay for miscellaneous diagnoses, such as those containing the words, "not elsewhere classified." The psychologist should also be aware that codes change from time to time. Modified codes are announced at least annually, sometimes by CMS.

D: Document Start and Stop Times

Most insurers require health care professionals to indicate the start and stop times for each session that they bill for. It is not sufficient to put the length of the session (e.g., 40 minutes), but rather the actual times in which the session started and ended (e.g., 10:01 AM to 10:42 AM). This is important especially when insurance companies look to distinguish 90837 codes from 90834 codes.

D: Dual Eligible

Dual eligible refers to individuals who are covered by both Medicare (which is always primary) and Medical Assistance (Medicaid, which is always secondary). Dual eligible Medicare beneficiaries may not be billed for coinsurance or deductibles, although in some cases Medical Assistance will pay them or a portion of them.

E: Electronic Record

Nothing requires psychologists to keep their records electronically, despite rumors to the contrary. It is true that some institutions may require their employees to use electronic medical records, but that is an institutional requirement. Also, physician practices that accepted federal money to develop electronic health records must use them (***meaningful use***), so psychologists who work in those practices may have to use electronic records, but that is not because they are psychologists; it is because they work in a practice that has obligated itself to use such records. Medicare does require electronic billing after a certain volume of billing is reached but it is quite high– far beyond most psychology practices.

E: Employee Assistance Programs

Some employers offer Employee Assistance Programs (EAPs) to their employees. The benefit may include short-

term mental health services (usually in the range of 3 to 10 sessions), typically at no cost to the patient. The benefit is separate from the mental health component of the patient's health insurance and may be open to dependents even if the employer's health insurance benefit does not cover them. Some, but not all, EAPs permit psychologists to continue to treat the patients through their health insurance after the patients have exhausted their EAP benefit.

E: ERISA (The Employee Retirement Income Security Act)

ERISA is the Federal law that regulates health insurance plans of most large employers and unions. Any insurance plan covered by ERISA laws is regulated by the Federal government and is exempt from state laws. Most other commercial health insurance plans are regulated by state agencies.

F: Family, Marital or Individual Therapy?

When two or more people are involved in treatment, the treatment may be considered Family or Marital Therapy, or it may be considered individual therapy with an additional person present. It is important to clarify the nature of the treatment relationship at the outset of therapy when two or more parties are involved in therapy. The goal is to have unity or consistency in how the psychologist explains the nature of the sessions to all partners, and how the psychologist bills and documents the sessions. Problems can occur if these factors are incongruent. In these situations, the psychologists has obligations to the parties receiving the intervention and to the insurer (if any). Everyone needs to be on the same page as to how the psychologist will conceptualize and document the intervention. This has implications for the payment of services and the authority to control the release of information.

Psychologists have some choice, based on their therapeutic discretion, on how to handle these situations. Some psychologists believe that the "relationship" is the patient, consider both parties as equal participants in the treatment process, and document accordingly. This is entirely legitimate from a clinical perspective and can be done without any unusual problems if the patients are paying out of pocket. The psychologist needs to ensure that the patients understand that their relationship is the focus of treatment, and document accordingly, reminding the patients that insurance will not pay for these sessions (since no one has a mental illness) and that both parties will collectively have control of the release of information.

However, psychologists who bill third parties need to ensure that the treatment meets the standards of medical necessity which requires the psychologist to identify one individual as the patient who has a mental disorder, develop a treatment reasonably likely to alleviate that disorder, and document accordingly. Furthermore, the psychologist needs to inform the partners that the identified patient will have control over any future release of records.

As a practical matter people seeking marital or couples counseling are usually experiencing great distress and it is not difficult to give a diagnosis to one or both parties. When providing couples counseling it is often true that both spouses may benefit from therapy and that the actual intervention will show concern and sensitivity to the well-being of both partners, including the one who is not identified as the patient. From the standpoint of therapy, the well-being of the partner is important for the outcome of treatment, although from the standpoint of the insurer, the well-being of the non-patient is only incidental. The concern, respect, and consideration that the psychologist shows to the non-patients may cause them to consider themselves as equally as the ones identified to the insurance company as the patients, although from the standpoint of the insurer that is not the case.

Nothing requires psychologists to get patients to sign an informed consent document explaining the nature of the treatment relationship. However, signing such a document may be helpful if it reduces the risk of misunderstanding or misinterpreting the nature of treatment.

F: First Session Free

Some psychologists advertise that they offer the first session free. In looking at the practical and ethical implications of this issue it is essential to ask what is meant by a session. Does it mean a 90791 including a detailed family history and mental status exam? Or does it mean something else? If psychologists are offering a first session for free they need to clarify what they are offering. They may be offering a 15-minute consultation over the phone wherein they get a general idea of the presenting problem of the patient, explain their services, discern the match between the psychologist's areas of expertise and the needs of the patient, and explore if the patient has the financial resources to pay for the services. It may help to refer to such services as a free initial consultation or the like rather than a psychotherapy session. Such free sessions present few problems and would be likely to be a helpful service to patients.

On the other hand, when psychologists offer a more comprehensive initial session, such as a face-to-face 90791, they may be setting up an expectation on the part of the patient that the psychologist is committed to initiating treatment with the patient. They may also entail legal obligations to the patient, such as offering crisis intervention services. Some psychologists have found that offering free initial consultation results in spending a lot of time making referrals and does not necessarily result in an increase in ongoing patients.

F: Flexible Spending Accounts

Flexible Spending Accounts (FSA) allow employees to set aside money to pay health care expenses with pre-tax dollars. A patient who has a FSA may use it to pay copays, deductibles, or for treatment with out-of-network providers. They may pay cash to the provider and get reimbursed, use special checks issued by the account, or use a credit card. Generally, the provider will be expected to provide a receipt for services. The provider or patient will usually be required to submit a claim to insurance before getting reimbursed for the remainder by an FSA. See also Health Savings Account. There are technical differences between FSAs and HSAs that are beyond the scope of this article.

F: Forensic Services and Insurance

At times patients will need psychological services for a legal issue. For example, they may need an evaluation as part of a child custody dispute or as part of a fitness for duty evaluation to enter an occupation. Health insurance will not always cover these services. The medical necessity criteria for health insurance requires that the service recipient has a medical disorder and that the intervention is reasonably calculated

to address that mental disorder. Also, some health insurance policies specifically exclude forensic evaluations. Even without that exclusion, a child custody evaluation does not presume the existence of a mental disorder. Instead, the evaluation focuses on parenting ability and the psychological traits relevant to parenting ability. It is possible, however, that health insurance could cover court-ordered treatment if the medical necessity requirements are otherwise met.

H: Health Maintenance Organizations (HMO)

An HMO is a type of health insurance plan that limits coverage from health care professionals who work for or contract with the HMO. They generally do not cover payments to out-of-network providers unless the patient has an emergency or has received preapproval to do so. HMOs often offer integrated services and emphasize prevention and wellness. HMOs differ from PPOs in the extent to which patients can access out-of-network professionals (see Preferred Provider Organizations).

H: Health Savings Accounts

Health savings accounts (HSA) allow employees to set aside money to pay health care expenses with pre-tax dollars. They are often used by companies with high-deductible medical plans; sometimes the company contributes to the plan. A patient who has a HSA may use it to pay copays, deductibles, or for treatment with out-of-network providers. They may pay cash to the provider and get reimbursed, use special checks issued by the account, or use a credit card. Generally, the provider will be expected to provide a receipt for services. The provider or patient will usually be required to submit a claim to insurance before getting reimbursed for the remainder by an HSA. See also Flexible Spending Account. There are technical differences between FSAs and HSAs that are beyond the scope of this article.

H: High Deductible Plans

Recent years have seen an increase in insurance plans with deductibles so high that middle or low-income patients are unable to afford psychological treatment. To help these patients, some psychologists may wish to over report how much the patients pay for services. For example, they may want to report to the insurance company that the patient paid $100 for the service, while they agree to a "wink-wink" arrangement for the patient to pay them only $50. Such arrangements are not permitted if the psychologist has a contract with the insurer that requires them to charge the contracted fee. However, it may be acceptable for psychologists to allow patients to delay or spread out their payment for their deductibles during the deductible period. Deductibles apply collectively to all medical services.

Psychologists should check regularly with health insurance companies to see if the patients have met their annual deductibles. Deductibles generally start at the beginning of the policy year which is usually, but not always, January 1.

H: Home Visits

Often psychologists have good reasons for providing services in a patient's home. Some patients may have mobility limitations. Other examples might be a one-time visit to assess hoarding, or the administering of a response prevention program to treat cleaning compulsions secondary to OCD. Psychologists may conduct psychotherapy in the patient's home when clinically appropriate and may charge for those services according to the provider's usual practice.

When insurance covers treatment, psychologists should indicate "Home" in the place of service on the claim form. Usually the code for home is 12. Many third-party payers permit psychologists to charge only for face-to-face time and do not include any allowance for travel time or expenses.

H: How Much Should I Charge for My Services?

Some psychologists have practices that are fee-for-service and do not depend on insurance contracts. Other psychologists offer educational testing, coaching, or forensic services that are outside of health care insurance. They may ask how much they should charge for these services.

Professional associations, such as PPA, are not permitted to recommend or to suggest fees to its members. However, we can say that psychologists can look at the rate charged by other psychologists in their community or the amount of investment in such services.

Generally, it is recommended that psychologists establish a set rate for each type of services (e.g., a rate of 90791, a rate for 90834, a rate for 90837, and a rate for evaluation services either by the hour or per test). The rate should generally be the highest that the psychologist charges for that service. If psychologists charge a lower rate for a service because, for example, of an insurance contract or because the patient has limited financial resources, then they should list the full charge on all bills and claim forms, along with a notation of the discounted amount.

Insurance Questions A to Z: Part 2 (I-P)

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I: ICD (International Classification of Diseases)

A uniform list of conditions affecting health, each of which is assigned an alphanumeric code for documentation purposes. ICD is published by the World Health Organization. The United States currently uses the 10th edition of ICD (ICD-10). ICD-10 codes largely correspond to DSM-5, but the two are not identical. Insurance billing requires the use of ICD-10, not DSM-5. ICD-11 is in development, but will likely not be used in the United States for at least several years.

I: Inactive Status

Psychologists who have insurance contracts should let insurance companies know if they are unavailable to accept new referrals or if anything interferes with their ability to schedule new patients. Not doing so leaves them vulnerable to being removed from an insurance company's panel. Some insurance companies request notification even for brief vacations, although many providers notify insurance companies only for an extended leave, such as for a medical absence. Sometimes psychologists can document this on the insurance company's provider website.

I: "Incident to Services"

Medicare regulates supervised services through its "Incident to" rules that govern services furnished incidental to the physician's professional services in the physician's office (whether located in a separate office suite or within an institution) or in a patient's home. These supervised services could include psychotherapy or testing. The providers provide direct supervision, which for purposes of Medicare means they are present in the office suite and immediately available if needed. In this context, the word physician includes psychologists.

Medicare regulates supervised services through its "Incident to" rules that govern services furnished incidental to the physician's professional services in the physician's office (whether located in a separate office suite or within an institution) or in a patient's home.

I: Intake Child Not Present

Sometimes psychologists believe it can be clinically indicated to conduct an initial interview (90791) on a child without having the child physically present. This would be hard to justify because the 90791 requires an evaluation of the mental status of the child. An option would be to code the first session as a 90846 (family psychotherapy without the patient present) and then code the first session with the child present as a 90791. Although the 90791 is usually the initial conduct with the patient, nothing requires that it must be billed as the initial contact.

L: Late Fees, No-Shows

Anecdotal data from psychologists indicate that the cancellation rate for psychotherapy may be as low as 3% for some practices, but 20% or higher for public agencies. Excessive cancellations or no shows are probably the result of a variety of factors, but at times may reflect a failure on the patients to value psychotherapy.

Insurance companies vary in how they handle no shows or late cancellations. Some insurers prohibit charging for late fees or cancellations. If the insurer does permit such charges, we recommend that psychologists give their patients advance notices of their cancellation fees, including addressing it in their informed consent document and having a notice on the office room wall. For example, one psychologist charged patients 50% of her usual fee if they failed to cancel within 24 hours. She has a credit card on file and will bill the patient's card for such no shows or late cancellations.

However, most psychologists implement these rules with discretion. For example, many psychologists will typically waive the fee for a person who has a history of attending reliability or if they presented a circumstance that was beyond their control. For example, one psychologist took on a patient who was just starting chemotherapy for cancer. Since she could not predict her level of discomfort at the time she started therapy, the psychologist agreed to see her at the end of the day and to allow her to cancel with very little notice.

L: Life Insurance

From time to time psychologists will receive requests from life insurance policies to provide information on patients for them to qualify for life insurance benefits. Life insurance companies do not offer health care benefits and HIPAA does not apply to them. Life insurance companies may withhold life insurance from patients who fail to allow them access to their psychotherapy records. One goal of life insurance companies is to exclude patients at a high risk of dying from suicide.

Our experience with life insurance companies has varied considerably. Some will accept a written letter; others will want the entire notes. We have heard of some companies that will only exclude a few persons who have a high risk of suicide while others will exclude all patients with a diagnosis of any kind of depression. Apparently, no one

informed these life insurance companies that major depression is not the diagnosis most closely linked to suicide.

M: Medical Assistance

Medical Assistance is the Medicaid program in Pennsylvania designed to offer health care benefits to those who have limited incomes or who have temporary disabilities. Although its basic structure is determined by the federal government, it is administered by the states and in Pennsylvania by the Department of Human Services. For more information on the Medical Assistance Program, please see the following website: http://www.dhs.pa.gov/citizens/healthcaremedicalassistance/. In Pennsylvania, almost all Medicaid services are administered through contracts given to private insurers called behavioral health managed care organizations (BHMCOs). Each county has the option of choosing its own BHMCO and psychologists need to contract with these BHMCOs and comply with their credentialing and services requirements. Reimbursement rates are established by each BHMCO.

M: Medicare

Medicare covers most individuals once they reach 65 years of age; younger persons who have a disability as determined by Social Security may be eligible for Medicare as well. Medicare Part A covers inpatient services and Medicare Part B covers doctor visits, including psychotherapy services. Medicare Part B is voluntary and requires a monthly premium. It is possible for patients to have Medicare Part A and not have Medicare Part B. Such patients will not have coverage for most outpatient medical services including psychotherapy.

Medicare is a fee-for-service insurance provider, although it is so heavily regulated that it functions in many ways like a hybrid of an HMO or PPO. Medicare requires an annual deductible ($183 for 2018) and a coinsurance of 20%. Private plans, called intermediaries, manage Medicare according to geographical area. The Medicare intermediary for Pennsylvania is Novitas. Some of the rules regulating psychiatric services are contained in a document published by Novitas called Local Coverage Determination (LCD) L35101. This document lists permitted CPT and diagnostic codes, among other information. The easiest way to find this document is to go to CMS.gov and type L35101 into the search box.

M: Medical Advantage Plans vs. Medicare Supplement Plans

Medicare supplement plans pay Medicare's deductibles and coinsurance amounts. Medicare Advantage Plans replace Medicare. A Medicare subscriber may have one or the other, but not both.

The Centers for Medicare and Medicaid Services (CMS) regulates Medicare supplement plans. It is usually not necessary to bill these supplement plans because Medicare forwards claims information to the registered supplement plans which pay the provider automatically, usually within 2 to 3 weeks after Medicare pays the claim. It is not necessary to be an in-network provider for Medicare supplement plans. For most patients, who have Medicare Part B and a supplement plan, the patients will have no out-of-pocket expenses, but this is not always true. Some Medicare supplement plans do have deductibles and/or copayments that the provider must charge to the patient.

Medicare covers most individuals once they reach 65 years of age; younger persons who have a disability as determined by Social Security may be eligible for Medicare as well.

Many commercial health care companies offer health insurance plans known as Medicare Advantage Plans, which Medicare beneficiaries may choose in lieu of traditional Medicare. When a beneficiary makes this choice, they give up traditional Medicare and instead receive a commercial plan modeled on an HMO, Point of Service (POS), or a PPO plan. Medicare pays part or all of the premium. The company that issues the policy manages the plan. Usually providers must be contracted by that plan to be paid for services. Many of the best-known players in the insurance industry offer these plans including Blue Cross and Blue Shield affiliates, Aetna, and United Health Care. Some United Healthcare plans are marketed under the AARP label.

Sometimes patients do not understand the difference between Medicare Supplement and Medicare Advantage Plans. They may report that they have Medicare Supplement Plans when, in fact, they have a Medicare Advantage Plan. Psychologists can verify coverage by calling Novitas at 877-235-8073 and following the prompts to determine eligibility.

M: Mental Health Carve-out

The company that pays for mental health services is not always the same as the patient's primary health insurance company. When mental health services are handled by a different company than other medical expenses, it is known as a carve-out plan. This can sometimes be confusing for both patients and providers. For example, if a mental health service is billed to the primary insurance company, the claim will be rejected. When checking benefits, it may appear that the patient has no mental health benefits. If that is the case, psychologists may need to track down who pays mental health claims. The Affordable Care Act requires that almost all health insurance plans include mental health, although that may be amended by the new tax law of 2017.

In Pennsylvania, Medicaid's mental health benefits are carved out to a designated Behavioral Health Managed Care Organization (BHMCO). While Medical Assistance recipients may have a choice of health insurance companies, generally they do not have a choice of BHMCO.

N: Navinet

Navinet is a health care collaborative wherein psychologists can enter its portal and access information on their patient's medical benefits. In some cases, the provider may also file claims on Navinet.

N: Noncovered Services

Insurance companies generally pay providers for face-to-face interventions (or sometimes telehealth services). However, sometimes patients may request services that are not covered by an insurance contract. They may, for example, request a meeting with their child's psychotherapist and the school, or a letter to an attorney concerning a potential law suit. Psychologists can bill for these services if they explain the cost of the

services ahead of time, in a manner consistent with the APA Ethics Code that requires that "as early as is feasible . . . psychologists and recipients of service reach an agreement specifying compensation and billing arrangements" (Standard 6.04a). It is advisable for psychologists to include language about non-covered services in their initial treatment agreement with their patients. If the service is minimal, psychologists can always waive any fee. However, having these agreements in writing at the start of treatment greatly reduces the likelihood of a misunderstanding about such charges.

N: National Provider Identifier (NPI)

The NPI is a 10-digit number assigned to health care professionals. Health plans covered by HIPAA must use the NPI when billing for services. Professionals can get their NPI by logging on to the website of the National Plan and Provider Enumeration System (NPPES).

O: Opt-Out of Medicare

Psychologists who qualify as *Clinical Psychologists* under Medicare must see Medicare beneficiaries in-network unless they "opt-out" of Medicare. Opting out requires psychologists to submit an opt-out document to their Medicare intermediary. The opt-out agreement stipulates that the psychologists may not bill Medicare for any patients for two years. This includes billing Medicare as a secondary payer.

If psychologists see a Medicare beneficiary during that time, that Medicare patient must sign a contract that notes that the patient will be responsible for Medicare covered services and that they will not submit a claim to Medicare or ask their psychologist to do so on their behalf. Also, it must note that the patient has been informed that they can seek services from another professional who has not opted out of Medicare, include the date that the opt-out period ends.

The link is too long to paste here; it may be easier simply to Google "Medicare>Novitas>Pennsylvania>Opt Out."

O: Out of Pocket Maximum

Some insurers have an annual out-of-pocket maximum. Once a patient has paid this amount in a calendar year, the insurance company will pay 100% of all future charges. At this point, the patient has no more responsibility to pay for copayments for the rest of the year.

The most common health insurers are often members of the Blue Cross and Blue Shield network. They usually cover specific geographical areas.

O: Out of State Blues

The most common health insurers are often members of the Blue Cross and Blue Shield network. They usually cover specific geographical areas. In most cases these companies have reciprocal billing arrangements with other Blue Cross and Blue Shield plans. A patient may be insured by a Blue Cross or Blue Shield plan that is not local to Pennsylvania, for example, the out of state company employs the patient. In Pennsylvania, psychologists will usually bill Highmark Blue Shield for services rendered in Pennsylvania for patients insured by out-of-state Blue Cross or Blue Shield plans. Highmark also usually pays claims for patients covered by Federal Employee Plans.

Psychologists should check with the insurance company about benefits and any authorization requirements before starting treatment. Also, they should check with Highmark Blue Shield to ensure that their contract permits them to receive reimbursement for treating patients covered by out-of-state Blue Cross and Blue Shield plans.

P: Patients Who Need Sign Language Interpreters

At times, psychologists may receive requests for services from patients who have impaired hearing and require a sign interpreter. According to the Americans with Disabilities Act (ADA), small businesses need to assume the costs of these interpreters. The ADA provides an exception if the interpreter would impose an undue burden on the business. While the term undue burden is not defined, commentators believe that it would be hard to justify for a psychologist who has only one hearing impaired patient or only has one every few years. Even then, the legal cost of proving this in court would far exceed the cost of the interpreter.

P: Post-Payment Review

At times insurers will contact a psychologist and demand the return of moneys that already have been paid for the delivery of services. Often these occur because the insurance has determined that the beneficiary was not eligible for the services delivered. Pennsylvania's Act 146 of 2016 now prohibits insurance companies from demanding the return of any payment beyond 24 months of the payment. The law allows for a few exceptions such as investigations of fraud or abuse. Psychologists can minimize the likelihood of post-payment review by checking on patient benefits before services begin and by reminding patients to inform them of any changes in their insurance benefits.

P: Preferred Provider Network (PPO)

A PPO is a type of health insurance plan where patients pay less if they use the health care professionals or facilities that belong to the plan's network. Some PPOs have point-of-service (POS) requirements wherein patients must receive a referral from a primary care physician before they can access specialty services. PPOs differ from HMOs primarily in the ease of accessing out-of-network providers (See HMOs).

P: Prompt Payment

Pennsylvania's prompt payment law requires health insurers to pay all clean claims within 45 days. The failure to do so would result in a penalty levied on the insurers. The major shortcoming of this law is that it applies only to companies that are regulated by the Pennsylvania Insurance Department, which is about 40% of all health care beneficiaries. Other insurers are not regulated by this law which gives rise to an occasional quick payment scheme (see" Quick Payment Schemes").

P: Point of Services (POS)

See discussion under Preferred Provider Network (PPO).

Insurance Questions A to Z: Part 3 (Q-Z)

Samuel Knapp, EdD, ABPP, Director of Professional Affairs
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Rachael Baturin, MPH, JD, Director of Legal and Regulatory Affairs,

Q: Quick Payment Schemes (Scams)

From time to time psychologists will receive notices from a company offering to settle outstanding debts for a discount. For example, if a psychologist were owed $1,000 from an insurer, the quick payment plan would ensure fast payment if the psychologist settled for a percentage of the original debt. Sometimes the discounts are quite steep (40% or more). We know of no reason why a psychologist would accept such a scheme, even if we assume that they can fulfill the promises they make. It makes little sense to accept such a deep discount in exchange for payment being expedited by a few days or weeks.

R: Record Copying Fees

No one set of prices applies to all situations where records must be copied. The most common reason for copying records is to send them to another health care professional. Most psychologists simply send them with no fee involved. Psychologists may charge fees for sending records if they note that such a fee would be required in their informed consent agreement that the patient accepts to at the start of treatment. Many psychologists are reluctant to charge for sending records to subsequent treatment providers because it gives an appearance of nickeling and diming patients for services that are generally considered just part of doing business. Other psychologists only include fees for very large documents that need to be copied and mailed out or charge fees only for forensic or non-therapeutic reasons.

Psychologists covered by HIPAA must give patients copies of their protected health information (PHI) for no fee. PHI refers to copies of assessments, time and dates of services, diagnosis, and a summary of treatment. Psychotherapy notes are not part of the PHI and psychologists may charge patients for sending them copies of their own psychotherapy notes provided that such fees were explained to patients at the time that service started.

Psychologists may charge fees for sending records if they note that such a fee would be required in their informed consent agreement that the patient accepts to at the start of treatment.

Pennsylvania limits what psychologists and other health care professionals may charge for records sent in response to a subpoena. The prices are established by the Pennsylvania Department of Health under Act 26 and PPA publishes the new rates each year in the Pennsylvania Psychologist. Although these fees are only mandated in response to a subpoena, some psychologists will adopt the fee schedule as their standard for charging record copying fees for forensic or other non-therapeutic reasons. The Social Security Administration also sets maximum fees for records provided in support of a claim for Social Security benefits.

R: Red Flag Rules

The Federal Trade Commission uses the term red flag rules to refer to a series of steps that businesses must take when engaging with certain customers or consumers. Red flag rules require businesses to verify the identity of their consumers if they regularly defer payment of services. It is theoretically possible for psychologists and other health professionals to be covered by red flag rules, but for all intents and purposes, they are not because almost no psychologists regularly or routinely defer payments. Red flag rules do not apply when psychologists occasionally allow patients to defer payments or accrue debts. Nonetheless, some health care providers, including psychologists ask patients for a picture ID before beginning services.

S: Same Day Billing

Whether psychologists can bill for two or more services on the same day depends on the insurance company they deal with. For example, the psychologist may wish to provide both an individual session and a family therapy session on the same day, or an individual session and a group therapy session on the same day. This may be clinically indicated in certain clinical situations such as when using exposure treatment with trauma patients where two 90837s or a 90837 and a 90834 could be indicated for use on the same day. Psychologists who bill for two or more codes on the same day should ensure that the decision is well documented in their treatment notes. In some cases, the CPT modifier 59 may facilitate payments.

S: Supervised Services

Few commercial insurers reimburse for services provided by unlicensed or uncredentialled but licensed providers working under supervision or, if they do, they define supervised services very narrowly to refer to services provided with the supervisor physically present in the room.

S: Sliding Scales

Psychologists who have signed contracts with insurance companies must charge the fees and collect the copayments that they agreed to in their contracts. Many psychologists are concerned about helping persons who cannot afford psychotherapy. Those who work outside of insurance companies control their fees and have the flexibility to adjust them depending on the

Psychologists who work in an independent practice often ask if they are required to get an employee identification number.

patient needs. Some psychologists may request a pay stub or a copy of last year's tax return to verify income and then adjust the fee according to a formula based on income and number of dependents. Other psychologists will accept the patient's word on their financial situation. But, it is very hard to be completely fair because it is impossible to anticipate every contingency.

T: Tax ID (Employee Identification Number)

Psychologists who work in an independent practice often ask if they are required to get an employee identification number. They are not required to do so, but having an employee identification number reduces the availability of their social security number. Insurers keep track of the professionals in their networks by tracking either their social security or employee identification numbers. If professionals use an employee identification number, they will have less need to share their social security numbers. Professionals can get an employee identification number by going to the IRS website. They may also need a new NPI if they had previously been billing using their social security number.

T: Telepsychology Services

Telepsychology services require the consideration of several factors. First, are telepsychology services appropriate for this patient? Second, is the psychologist competent to provide these services. It is beyond the scope of this brief discussion to identify all the issues involved, but they include knowledge of the unique platform and confidentiality rules.

Insurers are inconsistent on paying for telehealth services. A wise rule of thumb is not to assume that insurance will cover it and either check with or have the patient check with their insurer on this issue. Also, insurance companies may have different standards or restrictions for the use of telehealth services.

Finally, delivering telehealth services across state lines involves unique challenges. Although we have not been able to find any case law dealing with this topic, a conservative assumption is that the service is being delivered in the jurisdiction where the patient is physically located. So, if the patient is physically located in Ohio, the assumption is that the service is being delivered in Ohio and the psychologist must be eligible to practice in Ohio. Fortunately, many states have temporary practice laws that allow out of state psychologists. However, prudent psychologists will check with the board of psychology in the relevant state before agreeing to provide services to persons living in those states. Also, these states sometimes have additional requirements for telehealth services, such as additional informed consent procedures.

Patients may receive treatment from psychologists under workers compensation, although the reimbursement is tied to 113% of Medicare's rates.

T: Testing

Insurance companies vary considerably in how they process claims for psychological testing. Many require pre-certifications or limit the number of hours allowable per test. Insurance companies, including Medicare, may have a limit on the number of hours they will authorize for a given test or battery. They will sometimes increase that authorization when a specific need is demonstrated. The testing codes such as 96101, etc. include time spent in administering, interpreting, writing up the test results, and giving feedback to patients. Most insurance companies do not cover tests designed to measure intelligence, academic achievement, or the presence of learning disabilities.

Some evaluations, such as screening for the use of lethal weapons or employment as a police officer do not qualify for third party reimbursement because they are done for purposes outside of the delivery of health care.

T: Tricare

Tricare is a program of health insurance benefits for members of the U.S. Armed Forces and their dependents. Tricare also sometimes includes former military personnel and their dependents. Tricare benefits are managed under contract by one or more health insurance companies. For 2018, Wisconsin Physicians Services will process claims in Pennsylvania.

W: Waiving Copayments

Psychologists may not, under any circumstances, waive copayments on a regular basis. However, some psychologists may wish to waive copayments on a case-by-case basis for some patients. Insurance companies vary on their policies concerning the selective waiving of copayments. Nonetheless, we urge that psychologists never allow copayments to go uncollected without a discussion with the patient and mutual decision concerning whether to waive copayments. It is best to have those discussions early in treatment. See Dual Eligible for an exception.

W: Workers Compensation

Workers compensation is an insurance program specifically designed for injured workers. Patients may receive treatment from psychologists under workers compensation, although the reimbursement is tied to 113% of Medicare's rates. However, some worker compensation programs are managed by health insurance companies, so sometimes psychologists will be obligated to accept lower rates because they have in-network agreements with that health insurer.

Patients should expect to have their records requested by a reviewer or Workers Compensation court. The most common problems arise when psychologists treat patients for issues that are not directly linked to the work accident. Documentation becomes very important in these situations. The reviewer should be able to read the notes and see the link between the issues addressed and the work-related injury. It is generally a good idea to contact the Worker's Compensation company or case manager to verify that the case is open and that it includes psychological treatment.

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2018 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2018, we are looking to expand these options—we hope you'll join us for one or more of these programs!

Calendar

The following programs are being offered either through cosponsorship or solely by PPA.

May 4, 2018
Preventing School Shootings
PPA Office
Harrisburg, PA

May 5, 2018
Networking Lunch—Iron Abbey (Non-CE)
Horsham, PA

May 11, 2018
PPA Lunch & Learn
PPA Office/Virtual Webinar Harrisburg, PA

June 13–16, 2018
PPA2018—PPA's Annual Convention
Doubletree Valley Forge
King of Prussia, PA

Home Study CE Courses

Act 74 CE Programs

Assessment, Management, and Treatment of Suicidal Patients—1 CE

Older Adults at Risk to Die From Suicide: Assessment Management and Treatment—1 CE

Assessment, Management, and Treatment of Suicidal Patients (Extended)—3 CEs

Essential Competencies When Working with Suicidal Patients—1 CE

Patients at Risk to Die From Suicide: Assessment, Management, and Intervention (Webinar)—1 CE

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—3 CE Version

Pennsylvania Child Abuse Recognition and Reporting—2 CE Version

General

Record Keeping for Psychologists in Pennsylvania—1 CE

Introduction to Telepsychology, Part 1, 2, and 3 (Webinar)—1 CE each

*Introduction to Ethical Decision Making**—3 CEs

*Competence, Advertising, Informed Consent, and Other Professional Issues**—3 CEs

*The New Confidentiality 2018**—3 CEs

This program qualifies for 3 contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.

For all Home Study CE courses above, contact: Judy Huntley, 717-232-3817, judy@papsy.org.

For CE programs sponsored by the Pennsylvania Psychological Association, visit papsy.org.

Registration materials and further conference information are available at papsy.org.