Navigating Insurance, Claims, and Billing

I. *How Claims Are Processed*

After you attend a session, a **claim** is submitted to your insurance company. This is basically a detailed bill that tells them what services were provided and requests payment according to your plan's benefits.

Here's a step-by-step overview of how claims are processed:

1. **Claim Submission**
   We submit the claim to your insurance company with all the necessary information (service type, date, diagnosis code, etc.).
2. **Claim Review**
   The insurance company reviews the claim to determine if the service is covered by your plan and how it will be paid. They check things like:
   - Whether your policy was active on the date of service.
   - If the service is covered under your plan.
   - Whether you have met your **deductible** or have **coinsurance/copays** that apply.
3. **Payment or Denial Decision**
   - If approved, the insurance company issues payment (if any) to the provider and sends both you and us an **Explanation of Benefits (EOB)**.
   - If **denied**, the provider (us) will be notified on the **EOB**. We will review the denial to understand why it happened—sometimes it's due to errors, coordination of benefits issues, or unmet deductibles. We will attempt to address the issue but may need action by you.

◆ **Important Note**:
Even when we check your **benefits** before your session, we are relying on the insurance company's information, which may not reflect the most current status (e.g., if your deductible has changed recently). We often don't know if the information was completely accurate until the claim is processed and the EOB is issued.

II. *What is an Explanation of Benefits (EOB), and how does it work?*

An **Explanation of Benefits (EOB)** is a document you receive after your insurance processes a claim. It outlines the details of the claim, including:

- **What was billed**: The amount your provider charged for the service.
- **What the insurance covered**: The amount the insurance paid, based on your benefits.
- **Your responsibility**: The remaining amount you owe, such as your copayment, coinsurance, or deductible.

It's important to remember that the **EOB is not a bill**. The EOB shows what your insurance company paid and what you are responsible for, but it is not the final amount that you may owe your provider. The provider will send you an actual bill for any remaining balance.

III. *What should I do if my claim is denied?*

If your claim is denied, don't panic. Here's what you can do:

1. **Review the EOB**: The EOB should explain why the claim was denied (e.g., lack of medical necessity, out-of-network provider, or incorrect coding).
2. **Contact the insurance company**: If you don't understand the denial, call the insurance company for clarification. Ask if the claim can be appealed.
3. **Appeal the denial**: If you believe the denial was incorrect, you have the right to appeal. The insurance company will provide instructions on how to do this. You may need to submit additional documentation or a letter of support from your provider.
4. **Follow up**: Keep track of your appeal status, and follow up regularly until a resolution is reached.

IV. *What's the difference between a copayment, coinsurance, and deductible?*

- **Copayment (Copay)**: A fixed amount you pay for a covered service, typically when you visit a healthcare provider (e.g., $25 per therapy session). It's usually due at the time of service.
- **Coinsurance**: A percentage of the total cost of the service that you are responsible for after meeting your deductible (e.g., you pay 20% of the cost of therapy after meeting your deductible).
- **Deductible**: The amount you must pay out-of-pocket before your insurance begins to pay for covered services. For example, if your deductible is $500, you will pay the first $500 of your medical costs before insurance covers the remaining costs.

V. *How does my therapist check my benefits, and why is the EOB important for confirming costs?*

As your therapist, we strive to verify your benefits with your insurance provider before your first session to give you an estimate of your out-of-pocket costs, such as copayments or coinsurance. However, it's important to note:

- **Pre-verification is an estimate**: When we check your benefits, we submit information to your insurance company about the services you plan to receive (e.g., therapy sessions). Based on this information, your insurance will provide us with an estimated coverage amount. This gives us a general idea of what your insurance will pay and what you may owe.
- **Accuracy is confirmed through the EOB**: Despite our best efforts, we cannot know for certain what your insurance will pay until they process the claim. The **EOB (Explanation of Benefits)** is the official document that shows what your insurance actually covered, what you owe, and whether there were any discrepancies.

- **Why discrepancies happen**: There can be differences between the benefits we check upfront and the amount covered by your insurance. This could be due to factors like:
    - Changes in your coverage since the initial benefits check.
    - Differences between the insurance company's understanding of the service provided and what we reported.
    - Errors in the insurance company's system: Sometimes, the insurance company may have incorrectly entered or processed your benefits in their system, which can lead to discrepancies in what they say will be covered versus what is actually covered.
    - Errors or issues in coding or claim submission.
- **What to do if there's a discrepancy**: If you see a difference between the estimated amount we gave you and what the EOB says, let us know! We can help you navigate the issue by reaching out to your insurance company or clarifying any details with them. In some cases, we may also help you appeal a denied claim or incorrect payment.

VI. ***Can I switch insurance plans during the year?***

While most insurance plans renew on a yearly basis, some plans may allow you to make changes outside of open enrollment periods (e.g., in cases of life events such as marriage, job change, or loss of coverage). If you change your insurance plan during the year, it's important to inform us of the change so we can update your benefits and billing accordingly.

VII. ***What happens if I change insurance plans at the beginning of the year?***

At the start of each year, many insurance plans reset their benefits and deductibles. Here's what you need to know:

- **Deductibles restart**: When your insurance plan renews at the beginning of the year, your deductible typically resets. This means that you'll need to pay out-of-pocket for services until your deductible is met again. For example, if your deductible is $500, you'll need to pay the first $500 of your healthcare costs before your insurance starts covering a larger portion of the costs.
- **Changing plans**: If you change to a new insurance plan at the beginning of the year, your deductible may be different from your previous plan. If you switch to a new plan mid-year, your deductible for that plan will apply, and the amount you've already paid toward your previous deductible will not carry over.
- **Benefits changes**: In addition to a new deductible, other aspects of your benefits may change, such as copayments, coinsurance rates, or the network of providers covered. It's important to verify your benefits with your new plan as soon as it takes effect to understand your coverage and out-of-pocket costs for the year.

- **Impact on therapy costs**: If you change your plan or if your deductible resets, it's important to understand that the amount you owe for therapy services may be different from the previous year. Always check your benefits to make sure you are aware of what to expect.

VIII. ***Do I need to let you know if I have secondary insurance?***

Yes, please! If you have **secondary insurance**, it's very important to let us know as soon as possible.

When you have both a **primary** and **secondary insurance**, they work together through a process called **Coordination of Benefits (COB)**. This determines which insurance pays first and how the remaining balance is handled. If we don't have accurate information about your secondary insurance:

- Claims may be **denied** or **delayed** because insurance companies need to know how to coordinate benefits.
- Your **primary insurance** may refuse to process claims correctly until they know about your secondary coverage.
- You could end up being billed incorrectly or paying more out-of-pocket than necessary.

◆ **What you can do**:

- Provide us with the **secondary insurance details** when you fill out your intake paperwork or if your insurance coverage changes.
- Notify us immediately if you **add or drop** a secondary policy at any time.

Having accurate information upfront helps us submit claims properly and avoid delays in processing. If you're unsure whether your secondary insurance applies to mental health services, we're happy to help you figure it out!