Insurance Benefits Verification Guide:

For families interested in attempting to access their health insurance coverage for services rendered at Chatham Speech and Myo, we strongly urge you to do a thorough verification of your benefits. We have created this guide to assist you with asking your insurance the “right questions” to better understand your insurance coverage.

Insurance Information That Is Needed Prior To You Making Your Insurance Verification Call:

Patient Name:_____ D.O.B_____

Primary Insurance Carrier_____ Phone # _____

Name of Insured_____ D.O.B_____

Insurance ID# _____ Group # _____

Important Information To Keep In Mind:

Verification of benefits is not a guarantee of coverage or payment. As you speak with an insurance representative, it is important to understand that many representatives can make mistakes and it is beneficial to get their name and contact info when possible. The phone calls are being recorded, and any reference numbers for the verification of benefits is extremely helpful.

One of the most important things to keep in mind is that just because a policy has a Speech Therapy benefit does not mean that the service is automatically covered. Please utilize our questions below to get a thorough understanding of your policies coverage. As a reminder, Chatham Speech and Myo is not contracted with any insurance carriers. Therefore you are verifying your out-of-network coverage as well as “GAP” coverage opportunities.

What To Say When Calling Insurance:

*I am calling to verify **out-of-network benefits** coverage (for myself) or my child:_____ for **Speech Therapy** in an **"office setting"** utilizing the following codes:*

Procedure Codes May Include Any Of The Following:

- 92523 (Speech Therapy Evaluation)
- 92507 (Speech Therapy)
- 92526 (Oral functional therapy – utilized for feeding therapy, myofunctional therapy and oral motor therapy)

Questions to ask:

1. What is the effective date of my policy?

2. Is the policy based on a calendar year benefit or policy year benefit?

3. Does my insurance coverage include out of network benefits for Speech Therapy services based on the codes above?

4. Is out of network coverage for Speech Therapy subject to an out of network deductible?

5. If yes, what is the-out of-network deductible?

6. How much of the-out of-network deductible have I satisfied?

7. What is the out-of-network out of pocket maximum? Family_____ Individual_____

8. How much of the out-of-network, out-of-pocket max have I satisfied?
Family_____ Individual _____

9. Is Pre-authorization necessary for any of the codes below:

- 92523 (Speech Therapy Evaluation)
- 92507 (Speech Therapy)
- 92526 (Oral functional therapy – utilized for feeding therapy, myofunctional therapy and oral motor therapy)

10. Do Speech Therapy visits go towards the out-of-network deductible, count towards treatment max?

11. Are Occupational Therapy and Speech Therapy visits reimbursed if they occur on the same treatment day? (Please be advised that some insurance companies don't cover more than one discipline in a day. Please confirm if you are receiving multiple services.)

12. Once the out-of-network deductible is satisfied, what is the percentage covered by my insurance plan if covered as a "co-insurance" benefit?

13. If the out-of-network benefit is via "co-pay" instead of "co-insurance" for Speech Therapy coverage, what is the out-of-network "copay" for Speech Therapy services:

14. What is the treatment max for SpeechTherapy?

15. Is the Occupational Therapy and Speech Therapy benefit a "shared benefit" (example 12 total visits between OT and SLP services)?

16. How many visits have been used to date of OT and or SLP benefit?

17. Can more visits be approved? If yes, how do we get more visits:

18. Is a doctor's prescription required?

19. Any non-covered pre-existing conditions as it relates to the Speech Therapy benefit? If yes, please explain:

20. Are there any exclusions listed on the "Evidence of Coverage" for Occupational Therapy or Speech Therapy? If yes, please provide exclusions:

21. Would I qualify for a “GAP Exception,” If yes, please details to process a “GAP Exception”

22. Where do I submit claims to or how do I submit out-of-network claims?

Attn:

Address:

City: State: Zip:

Notes:

Additional Information:

What is a “GAP exception”?

A network gap expectation is a tool health insurance providers use to compensate for gaps in their network of contracted healthcare providers. This is a way that clients may be able to access “in-network benefit coverage” from an out-of-network service provider.

What is the difference between a “deductible” and an “out-of-pocket maximum”?

The deductible is a dollar amount that you, the subscriber, must spend prior to the insurance carrier contributing their portion of the coverage/coinsurance (60%, etc.). Please keep in mind that just because you have a “deductible” does not mean that it necessarily applies to the service benefit, therefore always ask when verifying benefits if the “deductible applies.” The **out-of-pocket maximum** is the most you have to pay for covered services in a plan year. After you reach the out of pocket max, your health plan pays 100% of the costs of covered benefits.

What is the difference between a “copay” and “coinsurance”?

The copay is a specific amount of money that you spend on an office visit. A copay typically occurs when going to your primary care physician for the office visit and is a flat amount. **Coinsurance** is when insurance covers a specific percentage of the expenses for the covered service which results in the insurance subscriber paying the remaining percentage. Typically, specialty services such as SpeechTherapy are subject to coinsurance instead of a copay.

How likely is it to get approved for more visits beyond the initial visit allotment?

Typically, insurances will authorize an initial allotment (i.e., 12 visits of OT, PT, SLP combined benefit). However, they will state that more visits may be approved based on "medical necessity." This can often be misleading because often once the initial allotment is met, the benefit is exhausted. Medical review will be requested at the time each allotment is exhausted and perhaps additional visits will be approved. The process consists of submitting clinical documentation, case management review, and potentially additional steps of "peer to peer" review, etc. It is important to understand that these additional steps take time. Therefore clients should be prepared that not all visits will be covered by insurance and should be prepared to pay to allow for continuity of services for the patient.

If my insurance requires "pre- authorization," is there an additional charge?

Chatham Speech and Myo does have additional charges for any time outside of treatment time to request pre-authorization, additional medical necessity letters, peer to peer review, etc.

Is there anything I can do to improve the chances of being reimbursed:

There are several steps that we recommend for clients that want to pursue additional funding via insurance. Here are our recommendations:

- ☐ Do a proper verification of benefits to understand the benefit, the claims process, exclusions, and diagnoses that are not covered under your benefit.
- ☐ Submitting claims within 7 days from your "date of service" and following up within 14 days of your claim submission with insurance. Timeliness is essential when managing the claims submission process.

- [ ] Get a prescription or doctor's order from your Pediatrician. The doctor's order should state the following: Your child's name, date of birth, diagnosis, "Speech Therapy evaluation and treatment." – A doctor's prescription/order helps to support the medical necessity of the services regardless of the insurance requires a doctor's order.
- [ ] Submit a copy of your Speech Therapy Evaluation when submitting claims can help support the overall process. If you opted for the option to do an evaluation that didn't include a formal written report, there will be a fee to generate the report for your insurance purposes.
- [ ] Make sure that you have a superbill with appropriate codes and diagnosis codes based on procedures delivered and that clinical documentation is aligned with the procedure codes.