AH PRESCRIBING

How To: Getting Insurance Coverage for Private-Pay Services

It is increasingly common that small specialty medical and therapy practices are "private- or self-pay only." Sometimes, even when a practice is self-pay, services are still eligible for some coverage by the patient's health insurance. The process works differently than in-network services and requires a bit more paperwork from the patient, but it can be worth it to ensure you're able to access treatment with a provider who is a good fit for you.

The following FAQs address how "out-of-network" insurance coverage works, and how to go about requesting payment from your insurance company for specialty services. *This information is not meant to take the place of contacting your insurance provider(s) to understand their exact processes.*

What do "private- or self-pay only" and "out-of-network" mean?

Private- or self-pay clinics and practices do not contract with any insurance companies. This means they determine their own rates, rather than an insurance company dictating the rate or other aspects of the care provided. Many insurance companies mandate very low reimbursement rates for specialty providers, which is why it is common for these practices to be self- or private-pay only.

Private- or self-pay generally means the same thing as "out-of-network" services, though not exactly. As long as the provider is a certified, licensed medical or behavioral health professional, their services may qualify for at least some insurance coverage. When a private-pay provider explains that they don't "take" your insurance, this means that the provider is unable to submit claims to your insurance company on your behalf. However, you may be able to submit claims and be reimbursed. Keep reading for more details about this process.

How are claims submitted?

If you usually see providers who take your insurance (i.e., in-network with your insurance plan), your appointments probably look like this:

1. You give your insurance card to the provider's office.
2. You pay a copay at the appointment (if applicable).

3. The office submits the claim for payment to your insurance on your behalf.
4. You sometimes receive a bill from the provider's office a few weeks after the visit. The provider's office sends this bill to you after they hear back from your insurance plan how much of the cost your insurance will cover. Your insurance plan is informing the clinic how much to charge you, which is what is in the bill that you receive.

Out-of-network (and private- or self-pay only) providers usually work like this:

1. You pay the full cost of the visit before or at the time of service.
2. The clinic can provide you with a detailed receipt, called a "Superbill." A Superbill shows the amount you paid and all the medical information about the visit.
3. You submit the Superbill to your insurance company yourself.
4. If the service is approved by your insurance plan, your insurance company will mail you a check for reimbursement of their allowed/covered amount.

Is out-of-network coverage the same as in-network coverage? In most cases, the answer is no.

Some plans (including almost all HMOs) do not allow coverage or reimbursement for any out-of-network providers. If you choose a provider such as AH Prescribing who is out-of-network/private pay, your insurance plan would not reimburse or cover anything.

Many PPO plans, however, cover both in- and out-of-network services. Usually, in-network services are reimbursed/paid at a higher rate than out-of-network services. For example, your insurance plan may pay 80% of the insurance-allowed cost amount* for in-network services, but only 60% for out-of-network services.

Some plans may require additional paperwork to get out-of-network services covered, such as a preauthorization or precertification. This means that you would need to submit paperwork to insurance *before* services begin, alerting the insurance plan that you intend to see an out-of-network provider. Even if the diagnosis and service is generally approved by your insurance, *failure to complete this paperwork can result in denial of any out-of-network claims.* If you plan to submit claims yourself using a Superbill provided by AH Prescribing for out-of-network reimbursement, it's important to check if your plan has any preauthorization or other paperwork requirements.

What does "allowed amount" mean?

All insurance companies have "allowed amounts" for different health care services. This is the reimbursement rate/dollar amount that the insurance plan has decided they will pay for a given service. An important part of the agreement between providers and insurance companies is the insurance company's specific definition of the service(s) covered. In other words, the insurance company can dictate the timing and content of the services, and in many cases, interrupt or determine the course of care for patients by denying the practitioner or patient coverage for services or medications unless specified cost-savings measures for the insurance company are taken. Private- or self-pay and some out-of-network providers bypass

these insurance controls over their clinical decision making to varying degrees, allowing them to provide more individualized and specialty-driven care, prioritizing the patient-provider relationship and decision-making over insurance company profits.

Here's an example:

1. Your insurance plan has an "allowed amount" of $100 for one visit of speech therapy.
2. Your out-of-network provider charges $150 for one visit of speech therapy.
3. Your insurance plan covers out-of-network services at 60% of the allowed amount.
4. This means that your insurance plan will pay 60% of $100 (the plan's allowed amount), NOT 60% of $150 (what you paid the provider).

When you visit your self- private pay provider:

1. You pay $150 to the practice at the time of service.
2. You submit your claim/Superbill to your insurance company.
3. If approved, they will send you a check for $60 - which is 60% of your plan's allowed amount, NOT 60% of what the provider charges.

SUMMARY: How to get out-of-network / private pay services reimbursed by insurance

1. Check your plan information to see if you have out-of-network benefits.
2. If yes, check to see if preauthorization or other paperwork is required *before the appointment*.
3. Contact your insurance company to get information on how to submit claims to them yourself (U.S. mail, online through your insurance portal account, etc.).
4. Ask your provider if they can provide you with a Superbill to use when submitting a claim to your insurance company. At AH Prescribing, you will be able to access your Superbills through your OptiMantra Patient Portal.
5. Pay your provider the full amount at the time of scheduling or time of service.
6. Receive a Superbill for your visit from your provider.
7. Send the Superbill to your insurance plan, following the plan's requirements for other necessary paperwork.
8. Receive a reimbursement from your insurance plan paid directly to you.