HIGH FIVE
SPEECH THERAPY
PEDIATRIC SPEECH + LANGUAGE + FEEDING THERAPY
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OUT-OF-NETWORK INSURANCE BENEFITS:
SET YOURSELF UP FOR SUCCESS

This document can be used to help you find out if and how out-of-network insurance benefits are provided. Always familiarize yourself with the insurance terms listed at the end of this document prior to calling. Knowing what all the lingo is will absolutely help you navigate the system better!

*NOTE: Caregivers are ultimately responsible for determining details regarding insurance coverage and this document is simply offered to help you gather basic information. High 5 Speech Therapy and/or Emily Goudreault may not be held responsible for any loss of benefits or reimbursement if additional and significant information is not collected.

DETAILS REGARDING CALL

ALWAYS note the information below so if someone tells you a service is covered and then it is denied after the claim goes through, you can report exactly who you talked to and when (calls are often recorded and they can go back to the specific conversation). I can't tell you how many times this has saved a family from paying higher costs. **THIS STEP IS SO IMPORTANT!**

Person you spoke with:

Date: **Time:**

DETAILS REGARDING YOUR BENEFITS

How many speech therapy visits per year are covered AND/OR what is the maximum dollar amount?

Are those visits JUST for speech therapy alone, or is that speech therapy + physical therapy + occupational therapy combined?

How many visits have been used at this time?

Are there any exclusions for this benefit (e.g. specific ICD-10 codes or otherwise)?

Does our deductible have to be met prior to coverage of speech therapy visits? YES NO

If yes:

What is our deductible?

How much of our deductible has been met at this time?

Does our deductible reset on January 1 or a different date?

Is prior authorization needed for a speech/language evaluation? YES NO

(Note: Evaluations are billed as CPT Codes 92522 for just speech evaluation or 92523 for speech AND language evaluation. If you are unsure which your child would need, check with Emily)

If yes, how do I obtain prior authorization for an evaluation?

Is prior authorization needed for speech therapy? YES NO

(Note: One-on-one speech therapy is typically billed as CPT Code 92507)

If yes, how do I obtain prior authorization for therapy?

Do I need a predetermination note from my pediatrician or another doctor for speech therapy AND/OR an evaluation?

YES NO

If yes, can my pediatrician provide this?

What is the set co-pay AND/OR co-insurance per speech therapy visit?

Is there an allowed dollar amount for each out-of-network speech therapy visit? YES NO

If yes, what is it?

Is a treatment plan required for coverage of speech therapy visits? YES NO

If yes, are there any specific components that must be included?

How often must a treatment plan AND/OR evaluation be provided?

Is a progress note required for coverage of speech therapy visits? YES NO

If yes, are there any specific components that must be included?

If my out-of-network speech-language pathologist provides me with the following information for each session, is there anything else needed?

- Monthly or individual session invoice
- Current ICD-10 coding
- Current CPT coding
- Therapist state and national license information and certification information

What is the process for getting my out-of-network therapy sessions reimbursed?

Other questions/notes:

COMMON INSURANCE TERMS

Co-pay: People are most familiar with a co-pay. This is the specific amount of money that you pay for certain services. For example, it may be $15 co-pay for a doctor's visit or a $25 co-pay for a prescription - but either way you know exactly how much you will need to pay and it DOES NOT change based on the cost of the service. You pay your $15 co-pay whether the doctor charges $300 or $3000 for that service.

Co-insurance: This is the amount you will pay for each service and is based on a ratio or percentage that is set by your plan. For example if you have a 20% co-insurance then your plan's co-insurance ratio is 80/20. This means if your visit costs $100, then your insurance company will pay $80 and you will pay $20. If the same visit was $1000 then your insurance will pay $800 where you would pay $200. Therefore it DOES NOT stay the same as it is based on what the services cost. (NOTE: It is extremely rare for a health plan to have both a co-pay and a co-insurance that would be due for a particular service - it is usually one or the other.)

Deductible: This is the specified amount of money that you will pay out of pocket BEFORE insurance begins to cover any portion of the charges. It is important to specifically ask if your deductible has to be met prior to insurance kicking in as there are many plans that have a deductible; however, for many insurance plans, the patient does not have to meet the deductible for speech therapy services prior to insurance kicking in.

Maximum out-of-pocket: This is the maximum you will have to pay in a year. It is an accumulation of your deductible, co-pays and co-insurance. After the maximum out-of-pocket has been met then insurance will pay 100% for the remainder of charges. This may or may not apply for out-of-network speech therapy visits.

Prior authorization: Prior authorization is pre-approval from your health insurance plan that the specified service WILL be covered. If your health plan requires prior authorization for a service then it is required for you to obtain this approval **BEFORE** you have the service done. Otherwise, your insurance company can deny it even though they may have otherwise covered it. Most health plans have forms on their websites to download, fill out and fax in to get this approval. You will need to send the evaluation report, if available.

CPT code: This is a 5-digit numerical code that is used to describe medical procedures when billing insurance companies. Relevant speech therapy CPT codes include:

- 92507: one-on-one speech/language therapy services
- 92508: group speech/language therapy services (note that High 5 Speech Therapy does not consistently provide group therapy services, but does at times depending on schedule)
- 92522: evaluation of speech sound production (articulation, phonological process, apraxia, dysarthria)
- 92523: evaluation of language expression and comprehension (receptive language) AND evaluation of speech sound production (articulation, phonological process, apraxia, dysarthria)
- 92610: feeding assessment
- 92521: evaluation of speech fluency (stuttering, cluttering)
- 92524: behavioral and qualitative analysis of voice and resonance.

ICD-10 code: This is a coding system used to describe signs, symptoms, conditions, injuries or diseases. This may be obtained via an evaluation with a speech-language pathologist, doctor, neurologist, etc.

Exclusions: These are specific conditions (ICD-10 codes) not covered by an insurance plan.

Appeal: This is the course of action you can take when coverage of a service has been denied and you would like the insurance company to re-assess in the hopes that they may change their decision and cover the service previously denied.

Allowed amount: This is the amount that an insurance company bases their payment on. It is not necessarily the amount that the provider billed. For instance, the provider may bill $130 for a service, however, the insurance company only allows $100 for that service so the co-insurance amount is based on that allowed amount and not the billed amount from the provider.

In-Network: Most insurance plans have different coverage based on whether the provider is "in-network or out-of-network". Co-pays, co-insurance and deductibles are often lower for in-network providers. To be considered in-network, the provider has to have a contract signed with the insurance company. does not allow a provider to bill the patient for the amount over what insurance allows.

Out-of-network: Patients may pay more for co-pays, co-insurance and deductibles when utilizing an out-of-network provider. They will also often incur the additional cost above what the insurance's allowed amount is. For example, your insurance may reimburse up to $150 for a particular service but the provider normally charges $200 for this service. If your co-pay is $25.00 then you will pay $25.00 in addition to the $50 ($200 minus $150) not allowed by insurance. Especially with the big changes happening with health insurance, many providers choose to be out-of-network providers so that they do not have to take such a big deduction in their reimbursement rates.

Medical Necessity: Many insurance plans will only pay for services that they feel are "medically necessary." This often means that they will require reports from therapists, physicians, etc. and will utilize their own professionals to conduct an evaluation of these reports in determining if there is a medical necessity for the patient to receive the services in question.

Explanation of Benefits (EOB): This is a summary of the billed service where you are able to see what portion was applied to deductible/co-pay/co-insurance, etc. It will also tell you when services are denied and why.