Insurance and Therapy:

Things to Consider

Psychotherapy is a wonderful investment. However, as with all investments, people want to consider their options. Using health insurance for mental or behavioral health care services is fantastic option for those who participate in managed care plans. However, in comparison with "regular" medical coverage, many who participate in managed care don't fully understand the extent of their coverage and thus aren't taking full advantage of their plans. If you are curious about what types of services may qualify for insurance reimbursement and how to discuss your coverage with your health care provider, here are some answers to common questions about using your insurance for psychological services.

Does my health insurance plan cover psychological services like psychotherapy and/or psychological assessment?

Chances are, your plan does offer some kind of coverage for mental or behavioral health services. However, you need to refer back to your health coverage information or speak with a customer service representative to learn more about the extent of those services and whether or not there may be special requirements for pre-approval or pre-authorization before you can participate in care. Some people ask the mental/behavioral health care provider that they are interested in working with to double-check their coverage with their insurance company. Many providers will do this as a courtesy. However, a provider's willingness to check for you won't absolve you of any responsibility to know your coverage in case your insurance challenges the reimbursement. If your insurance challenges the reimbursement, you may be responsible for the full amount of services. So, it's really important you get accurate information about what is or is not covered. Read on to learn more about how to discuss coverage with your provider.

What do I need to ask my insurance provider when I talk to them about my coverage?

It can be helpful to have an idea of the type of services you want to participate in (for example, outpatient therapy, a residential treatment program for substance abuse, a brief group for people diagnosed with a medical condition) as well as whether or not the Psychologist you are interested in is "in-network" with your preferred provider when you talk to them about coverage. Once you have that information, here are some basic questions to get you started:

- What is my co-pay per session for in-network providers?
- Do I have a limit for number of sessions? If so, how many sessions are covered over what time period? When do my covered sessions renew?
- Do you outsource behavioral health coverage to a third party? If so, is Dr. Psychologist also considered an in-network provider on that panel?
- Do I have coverage for tele-mental health services? If so, is Dr. Psychologist considered an approved provider for those services? What is my co-pay for tele-mental health services?
- I know Dr. Psychologist is considered an out-of-network provider. Do I have out-of-network benefits for behavioral health services? If so, what percentage do you cover? What is my deductible, and how much of the deductible have I met?
- I plan to submit documentation to you for out-of-network reimbursement for Dr. Psychologist. How do I access any forms I need from you to submit my request for reimbursement?

If a provider is in-network, is coverage/reimbursement for the psychological services that I'm interested in guaranteed?
Unfortunately, no. Psychological services are typically covered under the same guidelines as medical care. This means that services must be considered "medically necessary" to qualify for coverage. In other words, that you need to have a diagnosable mental or behavioral health condition to qualify for reimbursement. Your in-network provider will submit claims and other documentation to your insurance company on your behalf to receive reimbursement. However, if your company decides to challenge the necessity of the services, you may be responsible for the cost of services. Most providers will try to contest a decision on your behalf, but if your insurer is adamant about not paying, the cost of services will be your responsibility. This is why it's a good idea to be informed about your coverage for specific types of services *before* you receive them. No provider wants you to be stuck with surprise bills.

Are there any drawbacks to using my insurance for psychological services?
As noted above in the Questions section, you may learn that your insurance company limits the providers that you may choose to work with to those that are in-network and the type or frequency of services they decide to cover. While you can choose to participate in therapy beyond what is covered, this is something to be aware of.

Further, as mentioned earlier, services have to be considered "medically necessary" or diagnosable to be covered. This means that your provider will share your diagnosis with your health insurance company to justify coverage. This diagnosis will then become a part of your permanent medical record. Just as is the case with medical diagnoses, if you apply for future medical or life insurance coverage, your mental or behavioral health diagnosis may considered a pre-existing condition, and thus be factored into a determination of coverage or rate. Also, if you apply for or hold a job that requires a very detailed background investigation that includes a health record check (such as a high security clearance job, public service position, military or federal service job, or aviation job), your diagnoses may be included in background information given to your potential or current employer.

Finally, confidentiality may be impacted if your insurance provider decides to contest coverage. To further justify your claim, your insurer may request that your provider provide additional information about your treatment and progress beyond what is submitted in a claim. In this way, your services may not be fully confidential, in that you must grant permission for your insurer to receive this sensitive information if they request it, to cover services on your behalf. However, you could always contest the request for additional information and choose to pay for psychological services out-of-pocket.

If you have concerns about any of these issues, consider self-pay. You can use a health savings account (HSA) or flexible spending account (FSA) to cover the cost of services using pre-tax savings (*and potentially lower your tax bracket to boot!*). Some Psychologists may negotiate rates for potential clients who want to invest in care but are either uninsured or choose not to use their insurance for services.

Though this handout was not meant to be a comprehensive primer of things to consider if you are thinking about using your insurance for therapy, I do hope it has helped. Feel free to contact me by email or via the website to talk more.