authorized are not sufficient to give an accurate diagnosis, yet the insurer will not authorize additional visits without one. This puts the therapist in a position of having to take a "best guess" at a diagnosis, which is not in the best interests of the client. It is our opinion that no one should be given a mental illness diagnosis that is incorrect or exaggerated simply to get treatment paid for by the insurer.

Most insurance plans and managed care organizations have lists of professionals who are "in the plan". However, this necessitates your seeing professionals who are on the plan and who have availability to insured/managed care clients. They may have no particular expertise with the issues you present to treatment.

## Reason #4. Treatment Coverage

Numerous managed care plans do not cover marriage or family counseling, unless they are part of the treatment plan for a serious mental disorder or drug/alcohol problem. However, many times family involvement may be critical to the success of treatment.

Also, most insurers will not provide coverage for what are considered "adjustment" issues, which may be less serious (though they can become serious) and treated relatively quickly. **Billing a session as "individual" when it actually involved other family members is considered insurance fraud.**

## Reason #5. Usual and Customary Fees

Our fees for psychotherapy and psychological evaluations are considered "reasonable and customary" for psychotherapy and testing with a doctoral-level professional in this area. It is not feasible for us to hire the staff that would be necessary to handle insurance claims, especially given that many insurance companies and managed care plans will cover much less than our regular hourly rates. This consistent reduction in rates artificially lowers the "average" rates for therapists. While we are content not to raise our fees in line with other costs of living, we are not content to see them lowered by as much as 45%.

We hope this has explained some of the reasons for our policy of not accepting insurance directly. As stated in our consent form and website, we are happy to help you obtain reimbursement from your insurer by providing you with receipts or completing any standard health insurance claim form.

We appreciate your understanding.

**Direct line: (305) 799 9970**
**Office: (305) 668 0355**
**Fax: (305) 668 5311**

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**Plumer Building**
**5915 Ponce de Leon Blvd**
**Suite 49**
**Coral Gables, FL 33146**

# Why We Do Not Accept Managed Care Reimbursement for Psychological Services

Dear Clients,

An important part of your treatment here is your "informed consent". In order for you to make an informed choice, we have created this "disclosure statement" for your review.

If you are a member of an HMO, PPO or other insurer that provides coverage for psychological services, please read the following before making your choice regarding accessing those benefits.

Thank You,

Sophie Guellati-Salcedo, Ph.D.
Licensed Psychologist
PY7490

## Reason #1: Lack of Confidentiality

Managed care plans involve direct clinical management by the plan's "case managers". If you access psychological services through your managed care plan, your therapist will likely be required to disclose a significant amount of personal information related to your case.

This information is used by the managed care company to determine benefits, which are allocated at their own discretion. This directly impacts your right to confidentiality, and it is possible that your information will be stored in a computer system, which could be accessed by a large number of people.

The FBI and law enforcement officials can access your insurance information at any time. This information could be used to your disadvantage should a legal problem arise.

Furthermore, this lack of confidentiality may adversely affect your minor children who are clients as well. Should they ever desire to apply for certain jobs or the military, the information in their insurance files could be accessed and used against them. It should be noted that this may be especially true with regard to Attention-Deficit/Hyperactivity Disorder, which has been associated with lost employment and denial of admission to military service.

## Reason #2. Difficulty Obtaining Treatment Authorization

Due to the direct care management by managed care companies and their desire to keep costs at a minimum, getting therapy sessions authorized has become cumbersome and time consuming. Every plan has different requirements and standards for authorization. Usually they require a number of hours a week of paperwork and phone calls by the therapist in order to get authorizations. Some will even deny participants therapy while approving medications. It has also happened that the delivery of a service had been pre-approved and reimbursement denied once the service had been provided.

Managed care plans allow a certain number of sessions per year for each plan. For instance, your managed care plan may allow 20 sessions per year of outpatient psychotherapy. This does not mean that you can automatically access those benefits. Often, you have to be referred by a primary care physician member of the managed care plan.

Then, you may go through a phone interview with a manage care plan case manager. Then, you may have to contact several plan providers to find one accepting new clients, who has a convenient location, or who has expertise in your issues. Once you have found a provider, there may be a long wait for an appointment due to pre-authorization requirements. Then you are often given only one to three sessions to start (50 minutes per week – though you may feel you need more), as an assessment. Then you may need to wait for more visits to be authorized – often weeks of phone calls and paperwork flow back and forth between your provider and the managed care plan company. Sessions cannot be provided unless authorized, and sometimes this means there is a gap in treatment while more sessions are authorized. This causes your treatment to be inconsistent, broken up, and can cause you more anxiety not knowing if you will in fact get your benefits authorized at all. Some clients give up on their treatment due to these frustrations. It is our opinion that this is not good clinical practice.

Furthermore, some managed care plans want to control the treatment plan. Some will even dictate the specific treatment plan, which is often very subjective and may have deleterious effect on the therapeutic process. Some plans will determine when it is time to terminate treatment, even when the client continues to be in distress, or his/her problems have not become sufficiently manageable.

## Reason #3: Diagnosis Requirements

Some insurers will not cover treatment unless it is considered "medically necessary". This may mean the client has to pretend they are "sicker" or more impaired than they really are, in order to receive benefits.

This situation puts both the therapist and the client at a disadvantage. Often the diagnostic or assessment sessions that are initially