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If You Intend to Seek Insurance Reimbursement

Bright Stars Pediatric Speech Therapy is a private-pay practice. We accept checks, major credit cards, and automatic withdrawal from your checking account (ACH). We are not affiliated with any insurance companies and we do not negotiate our fees.

If you intend to seek insurance reimbursement, please be aware:

1. **Must be "medically necessary":** Insurance companies often list speech therapy as a reimbursable service, but sometimes will *not* provide coverage for children's speech therapy services, particularly if the therapy is not due to a "medical" condition. For example, difficulties pronouncing an "r" sound would generally be considered an aesthetic issue rather than medical, and would likely be denied coverage. That said, treatment for autism spectrum disorder is required to be covered by CA law.
2. **HMO VS PPO:** If you participate in an HMO plan, such as Kaiser, they will not reimburse you for out-of-network services. If you belong to a PPO plan such as Aetna, United Healthcare, Anthem, etc., they may reimburse you for a portion of the bill, after you have met your deductible. They base their reimbursement rates on a portion of what they consider "reasonable and customary charges" for speech therapy services, which may be less than what we charge.
3. **Teletherapy:** Insurers may not reimburse for telehealth speech therapy. Please check your plan.
4. **Do you need pre-authorization?** The insurance companies are increasingly requiring a significant amount of paperwork—even though we are "out of network", including getting pre-approval for services. Please know that all pre-approvals/certifications are something that *you* must request from the insurance company, and track when re-authorizations are due, if a limited number of sessions are approved. Our staff is not set up to keep track of when they are due. We cannot tell you if your insurance company ultimately will reimburse you for services or for how much, even if your policy lists speech therapy as a covered service and pre-approves services. We do not call insurance companies for this information—you would need to do that if you need this information prior to beginning services.
5. **Keep your physician informed:** Since speech therapy is a "medical" condition under health insurance, keeping your child's physician in the loop is helpful. We have an Exchange of Information on our Patient History page 1 for this purpose as well as a separate form for this purpose. If we wrote the speech assessment report, we are happy to send a courtesy copy to your physician.
6. **Initial Assessments:** Insurance companies typically require a written initial assessment. They do not allow us to use the information from your child's IEP. If we do, it will typically trigger a denial on the grounds that we are duplicating school services or that the therapy is educational-not medical or rehabilitative- in nature. They will allow us to use other, private assessments if they are less than 6 months old as the basis for our treatment, but you should check to find out if they will require a separate assessment from us before initiating therapy. Insurance companies generally require that your child has a formal assessment every year. Our formal assessments include an initial treatment plan. Our "reassessments" include formal

and informal testing, a review of progress and updated goals.

7. **Additional Report Requests:** Any reports or documents which are requested to be prepared for your child, require a 3-week notice and are considered additional services. Any additional services should be requested via the "Additional Services Request" form, which details the associated fees with each document/form. If you had a comprehensive assessment with us, that includes a report.
8. **Initial Treatment Plans:** Along with an initial assessment, the insurance company will typically require an initial treatment plan. This is typically a description of the diagnostic codes and treatment goals. We prepare these as part of our intervention program and there is no additional charge to forward this information to your child's insurance company.
9. **Additional Reports:** Insurance companies may require additional progress reports (quarterly, every 6 months, or annually) and additional standardized testing. These reports are billed and considered an "additional service."
10. **Exchange of Information**: If you would like us to release our records/copies of reports to your insurance company, we need you to fill out and sign an Exchange of Information form for this purpose.
11. **Codes:** We will need to assign your child's therapy a service code (CPT—basically indicating whether the therapy was individual or group) and a diagnostic code (an ICD-10), which describes the disorder and include it on every receipt. <u>If you do not see one on your child's receipt, please let our office manager know</u>. The insurance company will require it, and if they have to send the receipts back to us to secure one, it will take much longer for you to be reimbursed. *Please don't ask our staff to use an inaccurate code or change dates of service in order to get reimbursed as that is insurance fraud and we could lose our licenses.*
12. **Individual & Group Therapy on the Same Day:** We have found that some insurance companies will decline to cover group and individual speech therapy on the same day. Although it can be logistically easier for you to get it all done on the same afternoon, be aware that some companies will refuse to pay in that situation.
13. **Send Reimbursement Checks to You**: Please make sure that your insurance company writes-and sends-the reimbursement checks <u>directly to you.</u> All checks sent to this office from an insurance company on behalf of a client will be returned to the insurance company with a letter directing them to reissue the check and send it to you. We cannot deposit, credit your account or co-sign checks that are received by our office in error.
14. **Our Staff's Involvement in Denials**: In general, our office staff cannot make calls to your insurance company to follow-up denials or a lack of response from them. Your reimbursement is between you and the insurance company. The only occasion where we will get directly involved and call is when the denial is triggered due to the fact that they did not receive the requested documentation from us or we are unsure as to what documentation they are requesting. Please know, we do provide the requested documentation in a timely manner, within a week. However, some insurance companies will indicate otherwise in order to drag their feet and limit their financial obligation to you. We keep careful records of when we send out requested information, and so if a denial is triggered for that reason or due to any clerical errors on our part, we will personally follow-up and write whatever letters are needed so you can resubmit your request. Other than that scenario, we will decline to get involved.