LAKEVIEW

SPEECH AND LANGUAGE CLINIC

OUT-OF-NETWORK BILLING POLICY

(p) 708-240-3874
(f) 773 598-8022
www.lakeviewspeech.com

Lakeview Speech & Language Clinic (LSLC) is only in-network with Blue Cross Blue Shield PPO and United PPO plans. Any other insurance plans are considered out-of-network. If your insurance coverage is out-of-network, you can still receive services with us. But it is imperative that you read this policy prior to starting therapy at Lakeview Speech.

OUT OF NETWORK POLICY:

If a client is submitting to an out of network insurance plan:

1. LSLC can call and verify benefits, but we recommend that the client also calls and verifies the information. Insurance companies often give more information to the subscriber than a provider.
2. Client pays for the full amount out of pocket (sliding scale based on income available)
3. LSLC provides a superbill for each session. LSLC can submit this to insurance, or client can submit this to insurance.
4. If the client's therapy is covered by insurance, the insurance will reimburse the client directly at whatever rate the coverage is.
    1. Coverage/reimbursement from the insurance company is NOT guaranteed.
    2. See full explanation for more information about reimbursement.

SUMMARY: The client must pay for the therapy session out of pocket. Reimbursement from their insurance company is not guaranteed.

FULL EXPLANATION:

Even when a practice does not accept your insurance, services are typically eligible for out-of-network insurance coverage. This works a little differently than "in-network" services. It can require a little more paperwork on your part as the patient, but it can be well worth it to ensure you're able to access treatment with a provider who is a good fit for you.

Unfortunately, many insurance companies mandate very low reimbursement rates for specialty providers, which is why providers are not able to be "in-network" for all insurance plans. But as long as the provider is a licensed healthcare professional, their services qualify for insurance coverage and can be billed "out-of-network."

If you normally see providers who "take" your insurance (in other words, they are in-network with your plan), your visits probably look like this:

1. You give your insurance card to the provider's office.
2. The provider submits the claim to insurance on your behalf.
3. You pay a copay at the visit (sometimes).
4. You receive a bill from the provider's office several weeks after the visit. The provider sends this bill to you only after they receive the claim back from your insurance plan. Your insurance plan tells the provider how much to charge you, which is what is in the bill that you receive.

Out-of-network billing typically works like this:

1. You pay the full cost of the visit up front, at the time of service.
2. The provider gives you a special receipt, showing the amount you paid and all the medical information about the visit. This is called a "superbill".
3. You submit this 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 the covered amount.

Some plans (including nearly all HMOs) do not permit any out-of-network coverage. Many PPO plans cover both in- and out-of-network services. Usually, in-network services are reimbursed at a higher rate than out-of-network services. For example, your insurance plan may pay 80% of the 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 basically means that you and/or the provider 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 for out-of-network reimbursement, it's important to check if your plan has any preauthorization or other paperwork requirements.

All insurance companies have "allowed amounts" for different health care services. This is the reimbursement rate that the insurance plan has decided they will pay for a given service.

If your plan covers out-of-network services at, say 60%, that is usually written as 60% of the allowed amount. This is usually different from what the provider actually charges.

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 rate), NOT 60% of $150 (what you paid the provider).

When you visit your provider:

1. You pay $150 to the practice at the time of service.
2. You submit your claim to your insurance company.
3. If approved, they will send you a check for $60 - which is 60% of your plan's allowed amount.

Summary: How to use OON billing

1. Check your plan information to see if you have out-of-network benefits
2. If yes, check to see if preauthorization or other advanced paperwork is required
3. Contact your plan to get information on how to submit claims to them yourself (snail mail, online through your member portal account, etc.)
4. Ask your provider if they can provide you with a superbill so that you can submit a claim to your insurance company (the vast majority will say yes)
5. Pay your provider the full amount at the time of service
6. Receive a superbill from your provider
7. Send the superbill to your insurance plan, following any requirements they have
8. Receive a check in the mail from your insurance plan