simplepractice

Getting Started with Insurance Billing

For Private Practice Speech-Language Pathologists

Introduction

Deciding to accept insurance is a big step for private practice. It may seem daunting, like an uphill battle, with a ton of red tape to get through, but it's also a great way to grow your potential client base.

Accepting insurance can provide a constant stream of referrals and expand the clientele that you're able to treat. This is why we've assembled this guide, which includes the following sections:

PART 1

The Credentialing/Paneling Process

When you join an insurance panel for the first time, you'll go through a process called credentialing. It is during this process that your contracted rate is determined. A contracted rate—also known as a negotiated rate, an allowed amount, or an agreed upon amount—refers to the amount an insurance payer agrees to reimburse for your services.

To become an in-network provider for an insurance company, you must first apply online by visiting the insurance company's website. After you apply, it's important that you fill out a Council for Affordable Quality Healthcare (CAQH) Pro View Application. The CAQH is where you will self-report your education, training, and experience. It may seem like a long and tedious application, but unless your information changes, you will only have to fill this out once.

All insurance companies will use this application to verify your qualifications. This entire process is slow, and persistent follow-up is key here.

All insurance companies will use this application to verify your qualifications. This entire process is slow, and persistent follow-up is key. It is important to document every interaction that you have with the insurance company, specifically the insurance representative's name that you spoke with and a reference number for the call. Be diligent and follow up at least twice a month.

6 QUESTIONS TO CONSIDER WHEN JOINING AN INSURANCE PANEL:

1. How quickly do you want to grow your practice?
2. Can you attract patients on your own?
3. Can clients in your community afford to pay out-of-pocket?
4. Can you perform the billing yourself or will you need to hire a biller?
5. Which insurance companies are the best to contract within my area?
6. Is the panel open to new providers?

PART 2

How to Decide Which Insurance Panels to Join

If you're not sure which insurance companies will be the most valuable for you to partner with, think about the population you are most interested in servicing and also consider the dominant employers in your area.

Do some research online or reach out to a colleague to find out what insurance they offer their employees. If a large percentage of your surrounding area is insured through Medicare or Medicaid, consider joining those panels. We also recommend researching which insurance payers have the most competitive reimbursement rates in your area.

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PART 3

Verifying a Client's Insurance Benefits

To verify a client's insurance benefits, you will need to collect the following information from your client:

- **Client Name, Birthdate, and Address:** client's legal name that the insurance company recognizes them by and address of the subscriber.

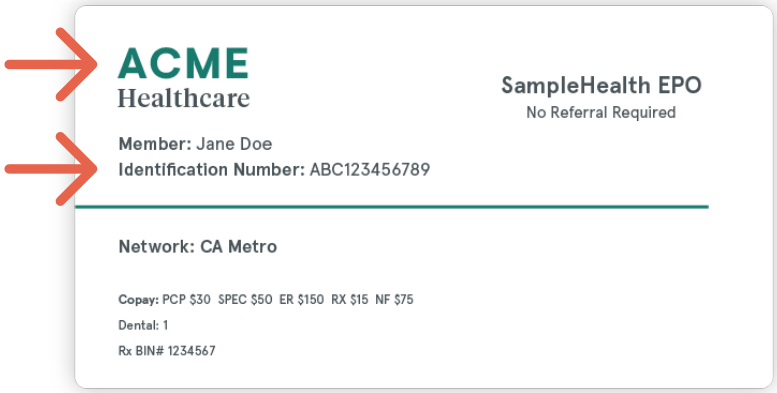
- **Subscriber's Name, Birthdate, and Social Security Number:** The policy subscriber may be your client, but it also could be your client's parent or a spouse. You can get benefits without the SSN; however, in situations where the representative can't locate your client's plan due to having an inaccurate Member ID number or Date of Birth, the SSN can be used to locate your client's policy.

- **Plan Name:** This can be found on the front of your client's card.

- **Member ID Number:** This is on the front of your client's insurance card. It can consist of both numbers and letters. May be referred to as subscriber ID, Policy Number, or Plan ID.

- **Phone Number for Providers:** This is usually located on the back of the card. If for some reason your client states that there is no number for providers on the back, then Google the payer's name followed by "provider phone number."

FRONT



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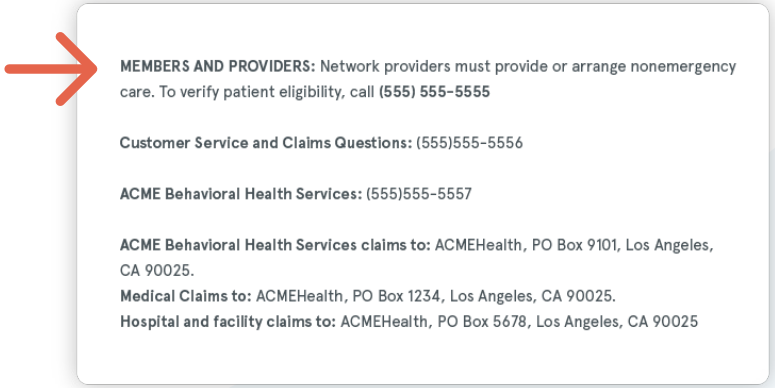

Verification of Benefits Tips

Calling a payer to get coverage confirmation can be tricky. Here's a checklist and script for when you get a representative on the phone.

INFO CHECKLIST

- ☐ Billing NPI
- ☐ Practice address
- ☐ Payer-specific provider number (if applicable)
- ☐ Client's full name
- ☐ Client's date-of-birth
- ☐ Client's subscriber ID
- ☐ Client's complete address or phone number

SCRIPT

1. On the automated prompt, indicate that you need to be connected with Provider Services.
2. "I would like to verify eligibility and benefits for Speech Therapy for a new client"
3. "Before we start, can you please confirm that I'm an in-network provider for this client's plan. My billing NPI is-"
4. If they are not in-network: "Do they have Out-of-network coverage?"
5. "Please verify that you have the correct address for my practice. It is..."
6. "The subscriber ID, DOB, first and last name, and client address are..."
7. "I need to confirm the following CPT codes..."
8. "I want to confirm if there is a number of visit limitation or authorization required for any of these services"
9. "What will the client pay for these services? Is there a copay?"
10. "Does this client have an outstanding deductible? If yes, how much have they accumulated towards it and how much is left?"
11. "What is this client's out-of-pocket maximum?"
12. "When did this policy begin and when will it end?"
13. "What address or electronic payer ID should I file these claims to?"
14. "Can you please provide me with your name and a call reference number?"

PART 4

Prior Authorization

When you verify a client's insurance policy, you may find that a prior authorization is required. A Prior Authorization, also known as a "pre authorization," or "pre certification," indicates that you must obtain consent from the insurance company prior to any services taking place. Insurance companies will often request a referral from your client's primary care physician, current diagnosis, planned treatment services, and medical information about your client to determine medical necessity.

For first time authorizations, we recommend calling. If you call an insurance company to discuss a pre-authorization make sure to note the time, date, the representative that you spoke with, and a reference number.

Prior authorizations can vary per insurance company and health plan. Some payers allow you to submit a request for an authorization online or by fax. For first time authorizations, we recommend calling. If you call an insurance company to discuss a pre-authorization make sure to note the time, date, the representative that you spoke with, and a reference number.

PART 5

Billing Basics

Understanding the difference between diagnostic and procedural codes is the first thing that you should know. **ICD-10 codes**, International Classification of Diseases, are used to diagnose a patient's condition. You must have the proper documentation to support this diagnosis. In cases where you were not the one to diagnose the client, you will need to know who the diagnosing physician was that gave the order for your client to receive the services that you provide. Documentation requirements vary by payer, but Medicare outpatient therapy guidelines are the criteria used by most payers for SLP services.

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Every October, ICD codes are updated. This means that codes can be added, revised, or deleted. It is essential to stay up to date yearly with these changing codes so that you don't find yourself using codes that are no longer accepted by insurance companies. If you accidentally bill an ICD-10 code that is no longer active, your claim will be denied. A great free resource that will not only tell you if a code is currently billable, but will also show you alternatives codes to use if your code is NOT billable, is **www.icd10data.com**.

If an insurance company ever questions your treatment of a client, you must be able to provide documentation that supports your treatment plan is medically necessary.

CPT codes, Current Procedural Terminology, are service codes that describe the procedure performed. This procedure can be an evaluation, a diagnostic procedure, or a treatment. Insurance companies identify the services that you provide from this code, and they require that providers document medical necessity for the provided services. If an insurance company ever questions your treatment of a client, you must be able to provide documentation that supports your treatment plan is medically necessary.

PART 6

CMS-1500 Form

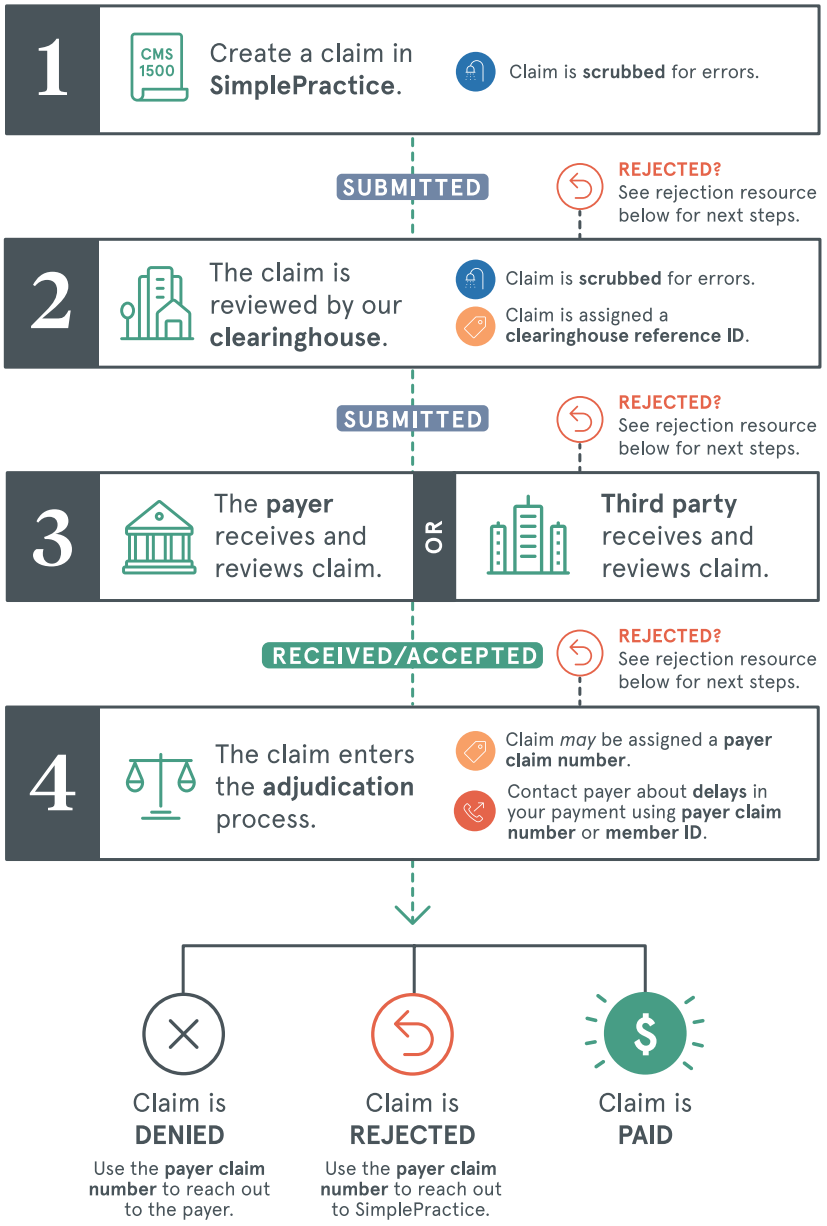
A CMS-1500 form has become the standard form used by all insurance carriers. Any non-institutional provider can use this form to bill medical claims.

SimplePractice allows you to not only create a CMS-1500 form straight from your Client Overview, you can also submit this claim electronically with the click of a button. If any important information is missing from the document, like a diagnosis code or the client's DOB, SimplePractice will alert you to this. Since we know a claim will get rejected without this information, you will not be able to create the form until all of the required information is in the client's record.

SimplePractice allows you to not only create a CMS-1500 form straight from your client page, you can also submit this claim electronically with the click of a button.

There's a lot that goes on after you submit a claim that you may not have considered before. Using the infographic to the right, you can follow the different paths a claim may take throughout its journey to payment.

The Journey of a Claim



PART 7

Reasons for Denial and the Appeals Process

There are many reasons a claim may be denied. SimplePractice uses a clearinghouse to scrub each and every claim and ensure that there are no obvious reasons why your claim could be denied. If you do receive a denial, review the Explanation of Benefits (EOB) or Electronic Remittance Advice (ERA) to understand the denial reason.

Here are some of the most common denial reasons that SLPs receive:

- **Does not meet medical necessity:** Certain cases may require a letter of medical necessity from your client's physician. The services you provide must be to treat an impairment, as opposed to a quality of life issue, and you must be able to associate the treatment that you are providing to the client's illness, disorder, or injury from accident.

- **Treatment is educational:** This denial reason indicates that the insurance company believes that the services you are providing are not treating an impairment. If you receive this denial, you must indicate your client's medical condition and explain why treatment of this condition is medically necessary. Keep in mind that SLP services are recognized by the Joint Commission, Medicare, and Medicaid.

- **Not a covered service:** This denial reason illustrates why it's so important that when you check a client's eligibility, you write down the date, time, representative that you spoke with, and a reference number. If you document that the insurance company has previously said they cover the service for which you're billing, you can use this information in an appeal. If you are able to, get a copy of the covered services for your client's policy.

There are many reasons why a client would not qualify for public school services, so it's important to explain to the insurance company why this client is not able to receive public school services and why your services are necessary.

- **Local public schools provide treatment:** Health insurance companies may try to claim your client does not need your services because he or she has access to public school SLP services. If you find yourself with this type of denial, provide the insurance company with information around why your services are needed. There are many reasons why a client would not qualify for public school services, so it's important to explain to the insurance company why this client is not able to receive public school services and why your services are necessary.

PART 8

Writing an Appeal

If you do not agree with the denial reason, then you can appeal the denial. The appeal process and time frame in which appeals are allowed varies by insurance provider. Once you understand the insurance companies appeal process, you can write a letter in compliance with the company's guidelines.

Send this letter to the appeals department via certified mail and request a return receipt. Follow up with this appeal and all communication you have with the insurance company. If you speak to anyone over the phone write down the time, date, representative that you spoke to, and a reference number.

DOWNLOAD THE FREE LETTER TEMPLATE:
http://ter.li/letter-templates

THE APPEALS LETTER INCLUDES:

Client Name

Treatment Code
(CPT Code)

Health Plan ID

Explanation
Why the claim shouldn't have been denied.

Dates of Service

Supporting Documents
Client's History, Physician Referral, Assessment Results, Progress notes

Total Billed Amount

Diagnosis
(ICD-10 Code)

Client's Policy
Covered Services Copy

PART 9

Negotiating a New Rate

Here are some things you should consider before reaching out to the payer to negotiate a new rate:

1. Contracted Rate Factors

- Number of years in practice
- Geographic location
- Level of education
- Areas of expertise and specialties, including additional certificates

2. Potential Differentiating Factors

- Do you speak multiple languages?
- Emergency or crisis treatment?
- Do you see a large number of clients?
- Do you serve in an underrepresented location?
- Early morning, late evening, or weekend hours?
- Home visits?
- Specialize with kids?
- Do you serve people with autism?
- Do you serve veterans?

OUR ADVICE: Wait about two years before negotiating pay unless you've made significant improvements.

Summary of Best Practices

1.
After collecting the potential client's information, call the insurer and verify benefits will cover their session.

2.
Be sure to communicate to your potential new client that even if benefits are verified, coverage is not guaranteed.

3.
After your first session with a new client who is covered under an in-network policy, submit your claim within a week of the visit, which will ensure you are paid quickly and also uncover any unforeseen issues that may prevent reimbursement and will require further discussion with your client.

4.
Your first session with a new client can be billed using the diagnostic CPT code, which is contracted at a slightly higher rate.

5.
For subsequent sessions, continue to submit claims in a timely manner and always include accurate and updated CPT codes.

6.
Collect copays at time of service using SimplePractice's AutoPay feature for daily invoicing.

7.
Practice proper documentation to validate your coding choices, as these records will protect you if you are subject to an insurance audit.

8.
Check your bank statement against the amount an insurer reports as paid to ensure the transaction was completed in full.

For Additional Help

Join the **SimplePractice Facebook community**, where thousands of our customers and our SimplePractice team help each other daily.

The **SimplePractice Help Center** has a wealth of information regarding best practices and calculating payroll.

Visit the **Help Center community**. Post, comment on, and vote for new product features with other customers like you.

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ABOUT SIMPLEPRACTICE

Trusted by over 35,000 customers, industry leader SimplePractice empowers health & wellness professionals to run their businesses more efficiently, streamlining administrative tasks, enabling regulatory compliance, and improving documentation and payments.

Offering features like a mobile app, paperless intake, customizable progress notes, Telehealth, secure messaging, integrated credit card processing, client scheduling, template library, and more, SimplePractice is a HIPAA compliant, fully integrated practice management platform.

Headquartered in Los Angeles, CA, the company ranked as the "#1 Most Popular Mental Health Software" on Capterra for both 2017 and 2018, and has collected over $1.8 billion in revenue for its customers.

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