Scott Andrews, Ph.D., H.S.P.
Forensic Evaluation and
Neuropsychological Testing

Phone: 978-342-4344
Fax: 978-627-8014
sandrews@psychtestingconsultants.com
www.psychtestingconsultants.com

MOST INSURANCE PLANS DO NOT COVER NEUROPSYCHOLOGICAL AND PSYCHO-EDUCATIONAL TESTING

Most insurance plans do not cover psychological testing unless they deem it to be "medically necessary." Any achievement testing or "educationally related" testing is not deemed medically necessary testing. Many insurance plans have an "exclusion" when it comes to psychological testing and thus are not required to cover it. If your insurance does cover testing, most likely they will not cover 100% of the 16 hours we require for a thorough evaluation. Most plans only pay between 40%-70% of the total 16 hours required. Some pay more, some pay less. The type of contract you or your employer has set up with the insurance company usually determines the percentage paid.

BENEFITS ARE NOT DETERMINED BY OUR OFFICE

Sometimes your insurer reimburses you at a lower rate than the provider's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your provider's fee has exceeded the usual, customary, or reasonable fee ("UCR") used by the company.

A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable, or well above what most providers in the area charge for a certain service. This can be very misleading and is not accurate.

Insurance companies set their own fee schedules, and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the "allowable" UCR Fee. Frequently, this data can be three to five years old, and the insurance company sets these "allowable" fees so they can make a net 20%-30% profit.

Unfortunately, insurance companies imply that your provider is "overcharging", rather than say that they are "underpaying", or that their benefits are low. In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

DEDUCTIBLES & CO-PAYMENTS MUST BE CONSIDERED

When estimating mental health benefits, deductibles and percentages must be considered. For example, assume the fee for service is $150.00. Assuming that the insurance company allows $150.00 as its usual and customary (UCR) fee, we can figure out what benefits will be paid. First a deductible (paid by you), we'll say $50, is subtracted, leaving $100.00. The plan then pays 80% for this particular procedure.

The insurance company will then pay 80% of $100.00, or $80.00. Out of a $150.00 fee they will pay an estimated $80.00 leaving a remaining portion of $70.00 (to be paid by the patient). Of course, if the UCR is less than $150.00 or your plan pays only at 50% then the insurance benefits will also be significantly less. Also, mental health/medical insurance deductibles can range anywhere from $50 - $2000+ (on average $250-$500).

APPEALS

As the subscriber to the policy, you have the right to appeal a determination your insurance company makes, this includes seeing an out-of-network provider when an in-network provider is not made reasonably available to you. In this case, payment is expected at the time of service. Upon request we are happy to give you a receipt that contains all necessary information commonly required to obtain out-of-network benefits. You may submit this to your insurance carrier, and they may reimburse you at least partially. We will try to work with you if you need to submit additional information. Please call your mental health insurance provider for more information about what your plan allows and requires.