Skagit Counseling Center

What is a superbill?

A form completed by your mental health provider that allows patients to be reimbursed directly from their health insurance companies. A superbill is a document that contains all of the information necessary for an insurance company or other third party to make a decision on reimbursement for health expenses incurred by a client. It is not a receipt. It is not an invoice. It is not a claim. A superbill is similar to a claim that you'd send an insurance company.

• Note: A superbill does not guarantee that an insurance provider will pay for the services provided. Each insurance plan is different, and it is your responsibility to contact your insurance provider and find out exactly what will be covered.

Why does Skagit Counseling Center not bill my insurance company for me?

Many professionals do not work directly with insurance companies, choosing rather to work independently. This ensures that your counselor makes clinical decisions that are purely based on professional expertise and not on health insurance policies.

Working with insurance companies results in less confidentiality for the client. When you use insurance to pay for therapy, your therapist is *required* to provide your diagnosis and treatment notes to your insurance company in order to get paid. This undermines the basic premise of therapy and also gives a lot more people access to private health information about you. It can also increase your insurance premiums.

Insurance companies operate on a medical model, which means they require a diagnosis to establish that you have "a medical necessity" to seek services in order to pay providers. This has Potential Negative Consequences for You! If given, the diagnosis will become a part of your medical record. While that might not be such a big deal right now, it may become one later on if you want to: get life insurance, work in the financial sector managing other's assets, regularly handle firearms, or seek employment in any sector in which your decision-making might be called into question due to your emotional state.

When therapists take insurance, they are required to use treatment methods that are covered by your plan. This means they have less say in how to treat you based on your specific and individual needs. Ironically, the people who work in your insurance company and decide which methods of therapy can be used, are usually not even therapists!

Additionally, Skagit Counseling Center does not bill insurance, we do not have to increase our costs to compensate for time spent managing paperwork. This keeps our services affordable for our clientele. The going rate for a great therapist in most major cities is between $150-$350 per session.

Most insurance companies pay therapists between $40-$90 per session. This is a fraction of what therapists receive from private pay clients *and* it requires a lot more paperwork and time to get paid by insurance companies.

How Do I Find What My Insurance Company Will Reimburse For An Out-Of-Network Provider?

The only way to know for sure what your insurance company will pay is to ask them directly. Prior to starting work with a counselor who uses superbills, you should contact your insurance company to find out.

Here Is How To Contact Them:

1. Call the customer service phone number listed on your card

2. Keep your insurance card handy as they will need your account information in order to answer questions about your specific plan.

3. Ask, "I want to work with an out-of-network Counselor, how much will you reimburse me?" Be sure to inform them that Skagit Counseling Center Counselors are licensed in the State of Washington.

4. Inquire about reimbursement for counseling appointments. You may also want to ask about the following things:

- Is pre-authorization required? (if applicable)
- Co-payment? (if applicable)
- Deductible? (if applicable)
- Today's accumulation for deductible? (if applicable)
- Co-insurance? (if applicable)

If pre-authorization is required, ask the representative to get this started. Many times, they will need to transfer the patient to the person who can grant the authorization. They will ask the patient's name, date of birth, and member number, along with the name and address of the mental health professional who will provide the therapy.

5. Ask, "What is the best way to submit my claim with superbill?"

Some options include fax, mail, or uploading Superbill Through Your Insurance Company's Portal. Your insurance company may have a portal that you can use to upload the Superbill. The portal is the insurance company's website that requires a username and password. This is the most secure way to transmit your Superbill, and the most timely.

When speaking to the representative, ask if the web portal requires an invitation from them to get started. If not, ask for the web address for the insurance portal. Typically, to create an account an email address will be required, along with a password.

6. Be sure that your benefits are clear to you. If anything is confusing, don't be afraid to ask the same question twice.

What Can I Expect After Submitting My Superbill?

When a claim is received by insurance, most insurance companies will make a determination in two weeks. If reimbursement is due after the claim is processed, most insurances have a specific day of the week when checks are mailed. When the claim is processed accurately and applied to the deductible, no payment is forthcoming.

I Submitted My Superbill & Received No Payment?

Generally, the Superbill will be processed within two weeks. After this time, with a copy of the Superbill in hand, call the "Member Services" number on the back of your healthcare card.

Ask the question, "What is the status of the claim submitted?" The representative will ask for dates of service and the total amount of the charges. Total amount is the accumulation of all the dates of service to include the date range on each page of a Superbill.

Insurance will inform you of the status of the claim(s) at the time of the call: Denied, in process, or completed:

- If a claim is denied, this is the time to ask the representative for the Denial reason, while on the phone. (see Denials reasons)
- In Process, the claims are currently in the process of being completed. Insurance is still completing the process of reviewing the claim(s) against the policy. Insurance has yet to make a final determinization on the claim(s). More time is needed for the insurance claims adjuster to "Finalize" the claim.
- Completed, means the claim is "Finalized." Finalized claims have two determinations:
    - 1) Money will be issued
    - 2) The amount for each claim was applied to the patient's deductible, meaning no reimbursement will be issued to the insurance member.

- Finalized Claim(s) payment will then be issued to the patient: Ask the representative for the dollar amount for each DOS and the total check amount.
    - How will the money be issued, by check or EFT?
    - When will the money be issued?
    - If mailing, confirm the mailing address?

- Finalized Claim(s) to the patient deductible with no payment issued: Ask the representative information on how the claim was determined. Insurance will list the amount for each date of service and the amount that was applied to the deductible. To understand the healthcare policy, ask for the total amount of the deductible and its accumulations.
    - Deductible Accumulations are the collection amount assigned to each therapy session. These accruals allow the total deductible to be obtained. After the deductible is met, then insurance will pay (minus the coinsurance, if applicable.)

My Superbill Was Denied – Now What?

In the case your claim(s) is denied, it is recommended to call insurance for them to explain the reason for the denial.

Possible reasons for your Superbill to be denied include:

Prior Authorization Was Required But Not Obtained
The Superbill was received and no prior authorization is on record. The insurance policy requires authorization to be obtained by the client, prior to the counseling session. No prior authorization was obtained, causing the claim(s) to be "Denied" on submission.

Possible remedy: Call "Member Services" with the Superbill "in-hand," ask about the status of the claim. If the claim was denied for "no prior authorization," ask if they can "back-date" the authorization, if possible. Either way, it would be beneficial to obtain a new authorization for future care with the provider of choice.

Date(s) of Service Was Outside the Timely Filing of Claims
The Superbill was received by insurance after the ninety-day period of the Date of Service. Any claims that are beyond the time frame of 91 days will be "Denied for timely filing."

Possible remedy: Call "Member Services" with the Superbill in-hand and ask about the status of the claim. Ask the representative if they can reconsider your Superbill, especially, if you are within 30 days of the timely filing date.

Information on the Superbill Was Incomplete or Illegible
The insurance carrier is stating that the Superbill received was not legible or did not include the required components on the form.

Possible remedy: Call "Member Services" with the Superbill in-hand and ask about the status of the claim. If they state that the form was incomplete or illegible, the representative will state the reason with what is missing or illegible. For example, the Provider's NPI or name are not present on the form, or the service code is not present on the form.

With the information the representative relays on the phone, examine the copy to see if the elements are present on the Superbill—maybe the insurance company received a bad copy. If they received a bad copy of the Superbill, it can be re-submitted by different means: Fax, mail, or insurance portal. In the case that the information was not present on the Superbill, take notes of the missing data and ask your provider for a Superbill with all the elements needed for successful submission.

No Out-of-Network Coverage
The Superbill is submitted to insurance and denied because the policy has no coverage for those providers that are not paneled to service the insurance members.

Possible remedy: Call "Member Services" with the Superbill in-hand and ask about the status of the claim. If the claim is denied for no out-of-network coverage, ask for a "Single Case Agreement," which is a contract allowing the specific provider to treat the insurance company's member or insured for a qualified number of sessions and/or date range. Many "Single Case Agreements" may be renewed at the discretion of the insurance company.

When an Insurance Company Will Not Accept a Superbill

Any insurance coverage inquiries require a call to "Member Services." This inquiry will be in regards to the claims for an individual provider.

If the claims are present in the insurance company system, the questions are different:

- How did the claim(s) finalize?
- How much was assigned for each Date of Service?
- To whom was the money sent—the patient or the provider?

We understand this can all be confusing. Please reach out if you have any questions (360)939-1450

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