Reimbursement for mental health services

Questions to ask your insurance provider

1. Do I have *out of network* benefits for mental health services? If not, how can I obtain *out of network* benefits? Do I need a pre-authorization from my primary care physician to use my *out of network* benefits?

   Most plans that offer out of network coverage will reimburse a percentage of their "reasonable and customary" (R&C) fee, after an out-of-pocket deductible is met.

2. Do I have a deductible?

   This is the amount your insurance provider expects you to pay before they will start reimbursing. Most plans have a yearly deductible.

3. What is the reasonable and customary fee for the following services in the 10024 zip code and percent reimbursement? The following table may be useful.

Code	R&C	% Reimbursable
90833 (30 minute psychotherapy add-on)		
90836 (45 minute psychotherapy add-on)		
99213 (Level 3 Evaluation and Management)		
99214 (Level 4 Evaluation and Management)		
99204 (Initial evaluation, moderate complexity)		
99205 (Initial evaluation, high complexity)		
90792 (Initial evaluation with medical services)		

   As a physician, I typically will use an E&M code with a psychotherapy addo on code. For instance, for a 30 min followo up appointment, the total R&C will be R&C of 99213 *plus* 90833. For a 45 min appointment, it will be 99213 *plus* 90836.

4. Does my plan have a maximum out-of-network annual limit?

Example:

The fee for service is $250 (45 min). After a $1,000 deductible (4 sessions), your plan reimburses 80% of their reasonable and customary rate (i.e. $100 for 99213 and $100 for 90836, totaling $200). So they reimburse 80% of $200, which is $160. You would then be responsible for $90 per session, after meeting your deductible.