

# Navigating the Mental Health Insurance Maze



What if you don't know anything about your insurance?



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Eligibility



Deductibles, copays, co-insurance



Authorization process

# What if you don't know anything about your insurance?



REVIEW YOUR BENEFITS  
ON YOUR INSURANCE  
PROVIDER'S PORTAL



CALL MEMBER SERVICES



EMBARK ADMISSIONS IS  
HAPPY TO GUIDE YOU

# What do we need to know?

- Deductible
- Co-insurance
- Co-payment
- Out-of-pocket maximum

# Benefit Breakdown



## **Deductible:**

- \$300.00 Calendar Year
- \$ 77.40 Met Year to Date
- \$222.60 Remaining Year to Date

## **Coinsurance:**

- Client 20% / Provider 80%

## **Copays:**

- \$0.00 Per Visit
- \$0.00 Per Admission

## **Out-of-Pocket Maximum**

- \$1,000.00 Calendar Year
- \$ 77.40 Met Year to Date
- \$922.60 Remaining Year to Date

Once the Out-of-Pocket Maximum has been met your health plan pays at 100% per calendar year.

# What are the components of authorizations?

*One size does not fit all*



## Precertification

Evaluates the patient's need **BEFORE** services are rendered.



## Concurrent Review

Entails **ONGOING** monitoring of the patient's clinical needs to ensure positive outcomes. Authorizations are renewed intermittently at time of expiration.



## Retrospective Review

Claim precedes authorization and auth request submitted with denied claim

# Medical Criteria for Different Levels of Care

*Each level of care will require specific criteria to obtain authorization*



## RTC

- 24/7 Monitoring
- Danger to Self/Others
- Functional Deficits across multiple areas of life



## PHP

- Step down from RTC
- Requires 20-30 hours of treatment weekly
- Short-term between inpatient and outpatient care



## IOP

- Step down from PHP
- Requires at least 9 hours of treatment weekly
- Longer-term treatment between PHP and OP



## OP

- Step down from IOP
- Requires at least 1 hour of treatment
- Mild symptoms not requiring higher level of care



# In-Network Benefits

*Requires provider enter into a contractual agreement with the payor*

**Network  
consists of  
contracted  
providers**

**Rate  
negotiation**

**Lower cost to the families:  
Lower annual deductibles  
co-insurance and  
out-of-pocket maximums**

**Generally  
quicker cash  
flow**

# Out-of-Network Benefits

*Requires plan coverage for out-of-network benefits*

**Non-  
contracted  
providers**

**Usual and  
customary  
rates**

**Higher cost to  
families:  
Higher annual  
deductibles, co-  
insurance and  
out-of-pocket maximums**

**Generally  
slower cash  
flow**

# Single Case Agreement

*Agreement between the provider and a non-contracted insurance company for one single client*

**Out-of-network  
however treated as if  
contracted and  
In-Network**

**Negotiated rates,  
possibly reduced**

**Less cost to the families:  
Lower annual  
deductibles,  
co-insurance and  
out-of-pocket maximums**

**Generally quicker  
cash flow**

# Closing the Loop

## Be your own advocate

**Provide quality  
medical  
documentation**

**Seek  
assistance  
from other  
medical  
professions**

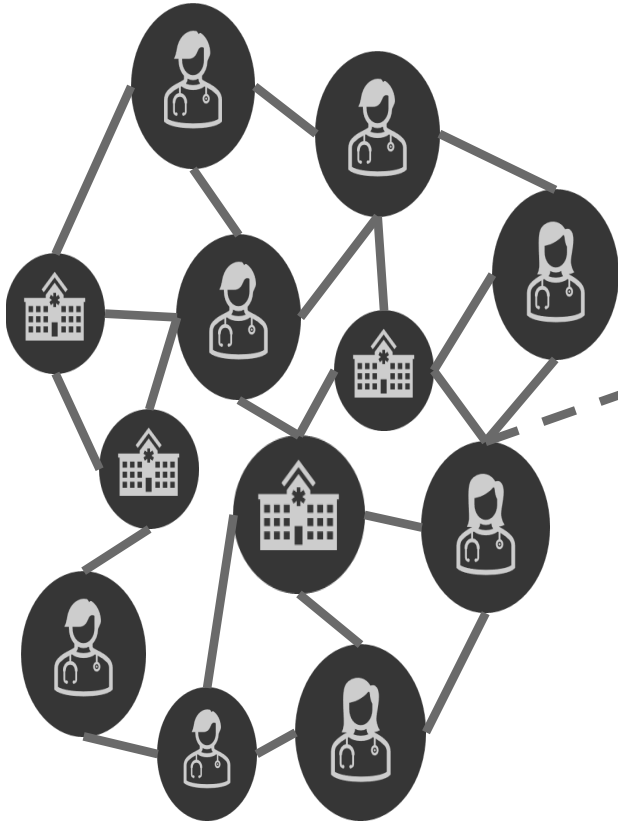
**Seek  
assistance  
from HR  
department**

**Stay close to  
the provider**

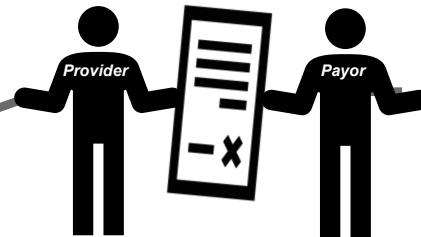
**Be the voice for  
your child  
Don't hold back  
on engaging with  
the insurance  
company**

# The Role of Payor Relations

## Medical Providers

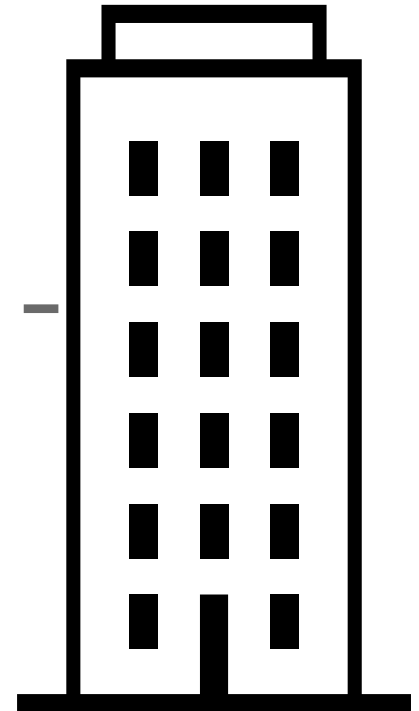


## Payor Relations



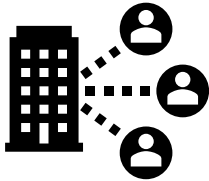
- Terms
- Conditions
- Quality
- Reimbursement

## Health Insurance



# Effective Advocacy

## The Consumer



Employers



Member

**Doctor Nomination Form**

**WE ALL HAVE DOCTORS THAT WE REALLY LIKE.**

If your favorite health care professional (a doctor, lab, hospital) isn't currently in the Cigna Open Access Plus Network, here's your chance to get them in. Simply submit this form by email to the address shown below. We will contact the health care professional regarding joining your Cigna Open Access Plus Network. We won't spam them or you; we're just giving them an opportunity to serve you.

Please keep in mind the submission of the health care professional nomination form is no way guarantee the physician or facility will be added to the network. However, Cigna will make every effort to expand its extensive network based on your referral(s).

Thank you for your time and we hope to get your health care professional in network!

Submit this completed form to: [PEProviderNominations@Cigna.com](mailto:PEProviderNominations@Cigna.com)

DOCTOR OR FACILITY NAME: \_\_\_\_\_  
 DOCTOR SPECIALTY: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 DOCTOR CITY & STATE: \_\_\_\_\_

**Nomination Form**  
*Consumer Choice Option*

By signing below, the Subscriber acknowledges that the nominated provider is not a Network provider. Subscriber further acknowledges that e or she alone is responsible for the selection of the nominated provider and that the plan has not undertaken nor will it undertake any underwriting or quality assurance measures regarding the provider. The member understands that any and all physicians, hospitals, and any other provider who are not Network providers must be nominated by the member (patient) and approved by the plan prior to any services being performed by the provider in order for the services to become eligible for reimbursement at in-Network benefit levels. Return this form to: **UnitedHealthcare, 1720 DeVine Ct., Ste 300, Norcross, GA 30092 ATTN: Consumer Choice Option** [Fax to: (770) 304-4367]

**TO BE COMPLETED BY THE SUBSCRIBER**

Subscriber Name: \_\_\_\_\_ Group Number: \_\_\_\_\_ Subscriber ID Number: \_\_\_\_\_  
 Subscriber Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 Subscriber Date of Birth: \_\_\_\_\_

Subscriber Name - Print: \_\_\_\_\_ Subscriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY THE PROVIDER**

Provider Name: \_\_\_\_\_  
 Group Name (if applicable): \_\_\_\_\_

**PHYSICIAN**

Physician Information

Physician Name: \_\_\_\_\_  
 Physician Address: \_\_\_\_\_  
 Physician City: \_\_\_\_\_  
 Physician State: \_\_\_\_\_  
 Physician Zip: \_\_\_\_\_  
 Physician Specialty: \_\_\_\_\_  
 Physician Hospital Affiliation: \_\_\_\_\_  
 Physician Office Phone Number: \_\_\_\_\_

**Medical Provider Nomination Form**

GEHA members, providers or office personnel may use this form to nominate a physician or hospital to the GEHA provider network. Complete the information below and select Submit to send this form electronically to GEHA.

All fields are required unless marked as optional.

**Provider Information**

Provider Tax ID #: \_\_\_\_\_  
 Provider First Name (optional): \_\_\_\_\_  
 Provider Middle Initial (optional): \_\_\_\_\_  
 Provider Last Name: \_\_\_\_\_  
 Facility Name: \_\_\_\_\_  
 Physical Address: \_\_\_\_\_

**Doctors & Hospitals - Provider Finder**

**Provider Nomination Form**

To nominate a physician to participate in the contracting provider network, complete the form below. Prior to submitting your nomination, check the Provider Finder or ask the provider about his/her network status.

The nomination process may take up to 90 days. Providers must meet all established credentialing requirements and must agree to all contract provisions, policies and procedures. In addition, there may be other reasons why a provider will not be accepted into a network. This nomination does not in any way guarantee that the provider will be accepted into the network.

An asterisk (\*) indicates a required field.

**Physician Information**

Physician First Name: \*  
 Physician Last Name: \*  
 Physician Middle Initial: \_\_\_\_\_  
 Hospital Affiliation: \_\_\_\_\_  
 Specialty Type: \*  
☐ Family Practice  
☐ Internal Medicine  
☐ Pediatrics  
☐ Other: \_\_\_\_\_

Address: \*  
 City: \*  
 State: \*  
 Zip Code: \*  
 Country: \_\_\_\_\_  
 Physician Office Phone Number: \*