Using Your Insurance for Neuropsychological Testing

We strongly advise that you get to know your insurance plan. Log in to the website and set-up an account if you'd like to track claims (the bills that are submitted), payments to your doctors, and the amount of fees that your insurance plan determines that you owe. We do not determine our rates; The insurance plans do that. We submit procedure codes with your diagnoses.

Neuropsychological testing is billed by the hour of our neuropsychologist's time. Since testing is a lengthy process, these hours usually add up to at least 8-12 hours for one evaluation.

We will submit the bills to your insurance company on your behalf, and they will provide you and our office with an "Explanation of Benefits" (EOB) *after they have processed your claims, usually in 3-4 weeks,* which reports which party is responsible for each amount billed. Sometimes, testing is covered under your co-pay for a "Specialist." This amount is on the front of your Insurance ID Card. For the three appointments – intake, testing, and feedback – you will be charged one copay for each appointment.

If we are out-of-network, you are self-pay. We will provide you with documentation to submit an out-of-network claim to your insurance: $1265 before 4/22 and $1465 after 4/22. The self-pay rate includes the intake, testing, results, report and feedback, as well as correspondence with your family members and physicians. It can be divided into three separate payments, with the last payment due at the time of feedback.

Both our office and you will receive the same EOB approximately 3-4 weeks after your appointments, and this documents the final amount. But since testing can add up to $900 or so, it is helpful to know what you will owe *ahead of time*:

1) To determine your portion of the bill(s) ahead of time, please call the Member Services # on the back of your insurance ID card and follow these guidelines:

2) Ask to speak to a representative

3) Provide the following CPT codes for all neuropsychological evaluations: 96116 (1 unit), 96132 (1 unit), 96133 (8 units)

4) Provide the following ICD codes for specific diagnoses. If you have more than one, or *think* you may have one diagnosis, provide them all and please document each:

    - Attention deficit/hyperactivity disorder - F90.9 and R41.82
    - Concussion(s) – S06.0X1S and F07.81
    - Memory Loss – R41.3
    - Depression – F32
    - Anxiety – F41.9
    - If you are unsure, please contact us or your referring physician and we will provide this for you

5) Once you have a representative on the phone, ask the following questions:
    - Have I met my deductible? If not, how much is left?
    - What is my co-pay or co-insurance that will be due?
    - What is your name?
    - What is the reference number for this call?

6) Write down this information and bring it with you to your first appointment. If you have questions, please call us at (706) 850-9339.

    If your evaluation is covered, that means that it has been deemed "medically necessary," but if it's not covered *under your co-pay*, then it is "*subject to deductible*." This means that you will be responsible for most or all of the fees that your insurance plan has determined to be appropriate, up until your deductible is met. After that, you may owe co-insurance, which is typically 20-30% of the remaining balance after you have paid your deductible. The individual deductible applies to your entire medical network. Therefore, if you need other diagnostics done with other doctors, such as an MRI, or have surgery, and you have paid the deductible, then for the rest of the year, you will either pay zero or pay the co-insurance.