Some psychologists are choosing not to participate on insurance panels (also called networks). While the insurance referral source is constant and the income stream can be more predictable, some psychologists decide to forgo serving on panels due to stagnant reimbursement rates, frustrations with billing and appeals, and perceived patient privacy concerns. Others find that some panels are “closed” and not accepting additional providers, so they are not able to participate.

But even psychologists who accept only private-pay clients¹ have to interact with insurance companies from time to time, such as when a patient submits a bill to their insurer. What information do private-pay practitioners still need to provide to insurers? What happens if a patient commits insurance fraud?

This article provides answers to those questions and additional examples of how insurance might still affect a private-pay practice.

WHEN PATIENTS GO OUT OF NETWORK
A patient may choose a psychologist who is not in their insurance network and utilize their out-of-network (OON) benefits by submitting the bill for direct

¹ Some psychologists prefer to use the word “client.” For purposes of the article, we use the word “patient.”

Even if you don’t accept insurance, you may still have to interact with insurance companies. Here’s what you need to know if you run—or want to run—a private-pay practice.

BY CONNIE GALIETTI, JD
Even though a nonparticipating provider has no contractual relationship with and no direct obligation to the insurer, the patient does.

reimbursement. In these cases, the patient may be obligated to provide certain information to the insurance company, including copies of treatment records. So, even though you, as a nonparticipating provider, have no contractual relationship with and no direct obligation to the insurer, the patient does. As a result, you may be required to respond to requests for records so that the patient can be reimbursed.

You should be sure your patients understand that if they decide to use their OON benefits, you may need to respond to requests from their insurer. So, be sure to include language in your informed consent forms allowing you to disclose protected health information (PHI) in response to reasonable requests from insurance companies, even though you don’t accept insurance. Patients should understand the consequences of you or them failing to comply with those requests and give you clear direction on how to respond should you be asked to provide records.

If the patient does not want you to provide treatment records or information to the insurer, honor their wishes. Just be sure they understand that they may not get reimbursed—and that they are still responsible for paying you.

To help your patients get reimbursed for your services, familiarize yourself with the record-keeping requirements of different payers. Many insurers require certain details in the patient’s record, which can usually be found on the provider section of the website. Some examples of required documentation in the clinical record might include:

» Member name or identification number on each page
» Presenting problems
» History and dates of service
» Start and stop times for therapy
» Treatment plans
» Progress notes
» Your signature

It is also advisable to keep records that document why this treatment was medically necessary. For example, any insurer review will go better if your records reflect, at least in basic terms, how your treatment is addressing your patient’s mental illness and/or its symptoms, as well as your patient’s progress toward objective treatment goals.

Remember that if you keep psychotherapy notes (as defined by the Health Insurance Portability and Accountability Act [HIPAA]), payers are generally not allowed to access them.2

FRAUD ALLEGATIONS
A few psychologists have reported receiving calls from insurers alerting them to suspicious OON claims by patients. In these instances, patients allegedly used old bills to create and submit claims for services they did not receive. One patient allegedly received close to $100,000 in reimbursement checks for services never provided. A key issue is whether you are permitted to confirm to insurers that services were provided on certain dates.

In most states, the combination of HIPAA and state law allows you to release PHI to insurers asking about dates of service if your patient

2 For additional tips on record-keeping to comply with HIPAA, see the Winter 2007 issue of Good Practice article “Practitioners: Take Note” available at apaservices.org/practice/good-practice/Winter07-Note.pdf.
has signed a consent form (typically at the start of treatment) covering releases to insurers or releases to insurers for payment issues. If you are unsure about your state law or the applicability of your consent form language to this scenario, or how to address potential fraud by a patient, contact your professional liability carrier or APA’s Legal and Regulatory Affairs Office, at spracticelegalandregulatory@apa.org.

GROUP PRACTICE IMPLICATIONS
What happens when a provider works for a group or facility that does accept insurance? If their employer accepts Cigna, for example, does a psychologist have to accept a Cigna patient in his/her outside private practice? It depends.

Typically, a group practice or facility will empanel employees with insurers under the group’s National Provider Identifier (NPI) number and location address (all of the providers in the practice, or facility, join the insurance panel). This allows the business to bill the insurer for the psychologist’s work with them; however, the “in-network” status does not automatically follow him/her to outside private practice. Psychologists with side private-pay practices (who are not themselves individually on the insurance panel) should check with the group or facility’s billing person to clarify whether the in-network status and contract applies only to work done for the group/facility.

TRANSITIONING TO PRIVATE PAY
Psychologists who want to discontinue accepting insurance and move to a private-pay business model need to be mindful of a few details when making the transition. They include:

» **HIPAA.** If the psychologist triggered HIPAA (for example, through electronic transmissions of patient information in connection with insurance claims), they need to continue to comply with HIPAA in their private-pay practice. At this time, there is no federal guidance that would allow a psychologist to escape continued HIPAA obligations. APA will continue to explore psychologists’ ability to step back from HIPAA compliance as they phase into retirement.

» **Contract terms.** During the transition, psychologists may be hesitant to quit panels because they want to finish treating existing patients, or just in case a former patient needs to be seen again. This becomes problematic if a patient with that insurance comes to the psychologist for treatment: The insurer may prohibit the psychologist from requiring the patient to pay out of pocket. Even if the patient agrees to pay that way, the psychologist may still be prohibited from charging more than the in-network rate. Review your contracts carefully regarding these issues, and for the necessary notice period and other procedures for you to terminate your contracts. Some psychologists also report problems with insurers claiming not to receive the psychologist’s notice that they are no longer part of the provider network. To avoid any problems, submit your termination notice according to the insurer’s requirements and also provide it in writing, such as by certified mail or email, so that you have proof. You should also check the insurance company’s website after termination to make sure that your name has been removed from their list of in-network providers.

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