



# NAVIGATING INSURANCE

FOR PEOPLE WHO STUTTER & THEIR PROVIDERS

FOR PATIENTS

## BEFORE YOU START THERAPY

1. Ask the provider if they are in-network or out-of-network with your insurance company
2. Ask the location of the service billing (office, inpatient, outpatient)

## WHAT TO KNOW BEFORE YOU CALL YOUR INSURANCE

The first part of the phone call will very likely involve working through an automated teleprompt system. This will give you some basic information about your coverage. In order to find out if you are covered for stuttering specifically, you will need to talk to a live representative. Many plans that cover speech therapy will not cover stuttering, so it's very important to verify to this level of detail.

## POTENTIAL PHONE CALL INFORMATION

### **CALL**

Call the Customer Service / Member Services number on the back of your insurance card.

### **VERIFICATION**

Follow prompts to Verify Benefits and Eligibility/ Verify Coverage.

### **SERVICE TYPE**

When prompted for type of service, say “*Speech Therapy*”.

### **NETWORK LEVEL**

When prompted for network level (in or out) and location, provide the information from your reference sheet.

### **NOTES**

Take notes using the worksheet provided.

### **SELECTING A REPRESENTATIVE**

When the automated information has finished, you should have an option to speak to a live representative. (If that option is not provided, press “0”—it will probably connect you through!)

### **SPEAKING TO A REPRESENTATIVE**

When the representative answers, say that you are calling to verify speech therapy benefits for a particular diagnosis.

*The representative will say one of two things:*

1. They will ask for the diagnosis (ICD-10) and procedure (CPT) codes. Provide them as listed on the reference sheet.

- If F80.81 is an approved diagnosis, they will tell you it is approved.
- If it is NOT approved, ask why. Depending on the reason for disapproval, you may be able to build a case explaining why stuttering should be covered under the stipulations of your coverage contract.

2. They will tell you that services are based on medical necessity, and that your individual case will be reviewed following the evaluation (ie, they can't tell you ahead of time on the phone). They may tell you that preauthorization/precertification is required. You can ask how to submit for predetermination to know if your services will be covered or not.

- If preauthorization is required or you would like a predetermination, this will need to be completed by your SLP.
- Use the worksheet to record what information your SLP will need to submit.

3. Ask for specific exclusions for the plan. If stuttering is listed specifically as an exclusion, appealing will waste your time. Also if the plan lists 'Specific coverage only for speech related to autism and home bound patients', that is important to know.

#### **OBTAINING PREAUTHORIZATION**

If the representative does not specifically mention preauthorization during your call, ask this at the end of your call.

# HELPFUL TERMINOLOGY

## PREAUTHORIZATION/PRE CERTIFICATION

This is a paper trail process that many insurance plans require in order for therapy to be approved. If preauthorization is not completed, services will be denied because you did not follow the proper procedure.

Typically, the provider (SLP) is responsible for opening the preauthorization case file with the insurance company, and ensuring all documentation is received. If your plan requires preauthorization, make sure your SLP is willing to submit all required documents.

If you start services without a preauthorization, and then file for preauthorization after the service, those services may not qualify for coverage, and you will be responsible for the entire fee.

## PREDETERMINATION

This is a similar process to preauthorization, but optional. The purpose of predetermination is to have your insurance company “preview” your desired services, to see if they will be approved for coverage. This is a very good idea for plans that require all services to be reviewed for medical necessity (ie: the representative can’t tell you on the phone if it will be covered or not). This will tell you ahead of time whether or not your plan will cover speech therapy, before you incur any costs from the SLP.

# PHONE CALL REFERENCE SHEET



## BEFORE YOU CALL

Insurance member ID: \_\_\_\_\_

Provider is: \_\_\_\_\_ in-network \_\_\_\_\_ out-of-network

Location is: \_\_\_\_\_ office \_\_\_\_\_ outpatient \_\_\_\_\_ inpatient

## PROCEDURE CODES (CPT):

92521 Evaluation of speech fluency

92507 Treatment of speech and language

## DIAGNOSIS CODE (ICD-10):

F80.81 Childhood onset fluency disorder\*

Note: this is specifically for stuttering that arises during childhood/adolescence. If stuttering has occurred due to an injury or traumatic event, check with your SLP for codes specific to this situation.

*\*Check with your SLP that this is the code they use for billing insurance. If they use a different code, ask for it.*

## DURING THE CALL

Deductible amount: \_\_\_\_\_ or N/A

Amount met so far: \_\_\_\_\_ or N/A

After meeting deductible, services are covered at  
\_\_\_\_\_ %

*(This means you pay the remaining % as a co-insurance)*

Copay: \$ \_\_\_\_\_ /visit

Maximum visits per year: \_\_\_\_\_

Is this maximum combined with physical and  
occupational therapy? Yes/No

Is preauthorization/precertification required? Yes/No

What is required for preauthorization?

\_\_\_\_\_ Referral from doctor

\_\_\_\_\_ Evaluation report

\_\_\_\_\_ Treatment plan

\_\_\_\_\_ Medical records

\_\_\_\_\_ Other: \_\_\_\_\_

How should preauthorization documents be submitted  
(fax number, etc.)? \_\_\_\_\_

If preauthorization is NOT required, but the representative cannot tell you ahead of time if services will be covered, ask to submit for predetermination.

What is required for predetermination?

\_\_\_\_\_ Referral from doctor

\_\_\_\_\_ Evaluation report

\_\_\_\_\_ Treatment plan

\_\_\_\_\_ Medical records

\_\_\_\_\_ Other: \_\_\_\_\_

How should preauthorization documents be submitted (fax number, etc.)? \_\_\_\_\_

IF YOUR CLAIM  
IS DENIED

## BEFORE YOU CALL

### **MAKE SURE YOU HAVE YOUR CLAIM REFERENCE (SEE WORKSHEET)**

Know that the representative you speak with will likely NOT have the authority to change the claim decision. The purpose of this call is to find out why your claim was denied, and how to go about appealing the denial.

Insurance arguments are typically made through post mail. You are gathering information so that you can build a case in writing, and send it to the appropriate department.

Keep in mind that while your SLP can assist by providing clinical documentation and information about stuttering, any disputes over cost responsibility are ultimately between you and your insurance company. By law, your insurance company is going to be more responsive to appeals from you than from your SLP.

## WHILE ON THE CALL

Ask for repetition and clarification whenever needed. Note-taking is very important. Make sure you write down all the information. Ask the representative for their name and a '*Phone Reference Number*'. This helps track your interactions with the insurance provider representative, should you need to phone again.

# CLAIM DENIAL WORKSHEET

Claim number: \_\_\_\_\_

Date(s) of service: \_\_\_\_\_

Practice/provider's name: \_\_\_\_\_

Amount(s) billed: \_\_\_\_\_

Why was my claim denied?

\_\_\_\_\_ That diagnosis isn't covered (1)

\_\_\_\_\_ Services are not medically necessary (2)

\_\_\_\_\_ Preauthorization was not completed (3)

\_\_\_\_\_ Other (ask for details!) (4)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How do I submit an appeal (fax, letter, etc.)?

\_\_\_\_\_

What is the address/number?

\_\_\_\_\_

What do I need to submit in my appeal?

\_\_\_\_\_ Copy of claim/EOB

\_\_\_\_\_ Appeal form (where do I find this?)

\_\_\_\_\_ Clinical documentation (what kind?)

\_\_\_\_\_ Letter explaining reason for appeal

\_\_\_\_\_ Other (ask for details!):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **(1) DIAGNOSIS NOT COVERED**

Some policies do not cover stuttering, which will be difficult to argue. However, many policies incorrectly classify stuttering as “developmental delay” or similar, in which case you may be able to explain why stuttering fits into a covered category. The following questions will help you understand the insurance company’s reason for denial so that you can make a case by providing facts about stuttering. Write everything down, especially terms or categories:

- Why isn’t this diagnosis covered?
- What diagnoses or diagnosis categories are covered?
- What does my policy say about what is and isn’t covered?

### **(2) SERVICES ARE NOT MEDICALLY NECESSARY**

This may be similar/identical to (1) above. However, this statement may also be used by insurance companies to claim that speech therapy for stuttering is not effective. The following questions will help you understand the insurance company’s reason for denial so that you can make a case by providing facts about stuttering and stuttering therapy. Write everything down, especially terms or categories:

- Why were services deemed not medically necessary?
- What defines medical necessity?
- Ask the representative for a ‘*Peer to Peer Review*’ prior to submitting an appeal. After speaking to the medical director who instigated the denial, they may make a correction during the peer to peer review which can resolve the issue more quickly.



### **(3) PREAUTHORIZATION WAS NOT COMPLETED**

This means that your plan requires paperwork to be submitted prior to starting services. Your paperwork was not submitted. See resource sheet on “Before You Start Therapy” for more information on preauthorization.

- How do I submit for preauthorization?
- Is it possible to get visits that happened before the preauthorization covered? (Usually not, but some plans are more forgiving than others.)

### **(4) OTHER**

Ask whatever questions you can to understand why it was denied. What is the insurance company’s rationale?

- Was this denied because proper paperwork was not submitted?
- Was this denied because of something with the diagnosis or type of medical service?

Depending on the nature of the denial, you will either need to make an administrative-based (paperwork process) appeal, or a clinical appeal (disputing their definition/explanation of stuttering).

FOR PROVIDERS

## BEFORE YOU START THERAPY

### WHAT TO KNOW BEFORE YOU CALL

The first part of the phone call will very likely involve working through an automated teleprompt system. This will give you some basic information about the patient's coverage. In order to find out if they are covered for stuttering specifically, you will need to talk to a live representative. Many plans that cover speech therapy will not cover stuttering, so it's very important to verify to this level of detail.

## POTENTIAL PHONE CALL INFORMATION

### **CALL**

Call the Provider Services number of the patient's insurance company.

### **VERIFICATION**

Follow prompts to Verify Benefits and Eligibility / Verify Coverage.

### **SERVICE TYPE**

When prompted for type of service, say "Speech Therapy".

### **NETWORK LEVEL**

When prompted for network level (in or out) and location, provide your information.

### **NOTES**

Take notes using the worksheet provided.

### **SELECTING A REPRESENTATIVE**

When the automated information has finished, you should have an option to speak to a live representative. (If that option is not provided, press "0"—it will probably connect you through!)

### **SPEAKING TO A REPRESENTATIVE**

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- If it is NOT approved, ask why. Depending on the reason for disapproval, you may be able to build a case explaining why stuttering should be covered under the stipulations of the patient's coverage contract.

2. They will tell you that services are based on medical necessity, and that the individual case will be reviewed following the evaluation (ie, they can't tell you ahead of time on the phone). They may tell you that preauthorization/precertification is required. You can ask how to submit for predetermination to know if services will be covered or not.

- If preauthorization is required or you would like a predetermination, you as the provider will need to complete this.
- Use the worksheet to record the necessary information and open a case file with the insurance company.
- Ask for specific exclusions for the plan. If stuttering is listed specifically as an exclusion, appealing will waste your time. If the plan lists 'Specific coverage only for speech related to autism and home bound patients', that is important to know.

### **OBTAINING PREAUTHORIZATION**

If the representative does not specifically mention preauthorization during your call, ask this at the end of your call.

### **REFERENCE NUMBER**

What is the reference number for this phone call?

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*(You will want this for cases of dispute.)*

# HELPFUL TERMINOLOGY

## PREAUTHORIZATION/PRE CERTIFICATION

This is a paper trail process that many insurance plans require in order for therapy to be approved. If preauthorization is not completed, services will be denied because you did not follow the proper procedure.

Typically, the provider (you as the SLP) is responsible for opening the preauthorization case file with the insurance company, and ensuring all documentation is received. Patients cannot do this on their own.

If services are rendered without a preauthorization, and then it is filed for after-the-fact, the already-completed services may not qualify for coverage. The patient will be responsible for the entire fee.

## PREDETERMINATION

This is a similar process to preauthorization, but it is optional. The purpose of predetermination is to have the insurance company “preview” the desired services, to see if they will be approved for coverage. This is a very good idea for plans that require all services to be reviewed for medical necessity (ie, the representative can’t tell you on the phone if it will be covered or not). It will tell you ahead of time whether or not the plan will cover speech therapy, before the patient is on the hook for any costs.

PHONE CALL  
REFERENCE SHEET



## BEFORE YOU CALL

Patient insurance ID number:

\_\_\_\_\_

Patient insurance group number:

\_\_\_\_\_

Patient DOB: \_\_\_\_\_

*(If the patient is not the primary insured on the policy, you will also need the name and DOB of the policyholder)*

I am: \_\_\_\_\_ in-network \_\_\_\_\_ out-of-network

Services will be rendered in:

\_\_\_\_\_ office \_\_\_\_\_ outpatient \_\_\_\_\_ inpatient

NPI: \_\_\_\_\_ and/or

Federal Tax ID: \_\_\_\_\_

## PROCEDURE CODES (CPT):

92521 Evaluation of speech fluency

92507 Treatment of speech and language

## DIAGNOSIS CODE (ICD-10):

F80.81 Childhood onset fluency disorder

*(Note: this is specifically for stuttering that arises during childhood/ adolescence. If stuttering has occurred due to an injury or traumatic event, use the appropriate codes.)*

## DURING THE CALL

*(Note: most plans use a deductible or copay for speech therapy. If you have a copay, the deductible will likely not apply. If you have a deductible, you likely will not have a copay.)*

Deductible amount: \_\_\_\_\_ or N/A

Amount met so far: \_\_\_\_\_ or N/A

After meeting deductible, services are covered at

\_\_\_\_\_ %

*(Patient pays the remaining % as a co-insurance)*

Copay: \$ \_\_\_\_\_ /visit

Maximum visits per year: \_\_\_\_\_

Is this maximum combined with physical and occupational therapy? Yes/No

Is preauthorization/precertification required? Yes/No

What is required for preauthorization?

\_\_\_\_\_ Referral from doctor

\_\_\_\_\_ Evaluation report

\_\_\_\_\_ Treatment plan

\_\_\_\_\_ Medical records

\_\_\_\_\_ Other: \_\_\_\_\_

How should preauthorization documents be submitted (fax number, etc.)? \_\_\_\_\_

If preauthorization is NOT required, but the representative cannot tell you ahead of time if services will be covered, as to submit for predetermination.

What is required for predetermination?

\_\_\_\_\_ Referral from doctor

\_\_\_\_\_ Evaluation report

\_\_\_\_\_ Treatment plan

\_\_\_\_\_ Medical records

\_\_\_\_\_ Other: \_\_\_\_\_

How should preauthorization documents be submitted (fax number, etc.)? \_\_\_\_\_

If preauthorization or predetermination is required, ask to open a case file. You will be provided with a reference number. Use this reference number when submitting documentation for the patient's case.

Reference/case number: \_\_\_\_\_

## LAST STEP

What is the reference number for this phone call?

\_\_\_\_\_  
*(You will want this for cases of dispute. This is not the same as a preauthorization case reference number.)*

IF A CLAIM  
IS DENIED

## BEFORE YOU CALL

### **MAKE SURE YOU HAVE THE CLAIM REFERENCE (SEE WORKSHEET).**

Know that the representative you speak with will likely NOT have the authority to change the claim decision. The purpose of this call is to find out why the claim was denied, and how to go about challenging the decision (or correcting the claim, if it was filed incorrectly). Insurance arguments are typically made through post mail. You are gathering information so that you can build a case in a written letter, and send it to the appropriate department.

Keep in mind that while you as the SLP can assist by providing clinical documentation and information about stuttering, any disputes over cost responsibility are ultimately between the patient and their insurance company. By law, the insurance company is going to be more responsive to appeals from patients than from you as the SLP. Sometimes insurance companies provide minimal responses to providers, which makes it difficult to advocate for patients. If you are making appeals on behalf of a patient and are being “shut out” by the insurance company, inform the patient that they need to become involved themselves.

## WHILE ON THE CALL

Ask for repetition and clarification whenever needed. Make sure you write down all the information.

# CLAIM DENIAL WORKSHEET

Claim number: \_\_\_\_\_

Patient insurance member ID: \_\_\_\_\_

Date(s) of service: \_\_\_\_\_

Billing NPI: \_\_\_\_\_

Amount(s) billed: \_\_\_\_\_

Representative Phone Reference Number:  
\_\_\_\_\_

Why was the claim denied?

\_\_\_\_\_ That diagnosis isn't covered (1)

\_\_\_\_\_ Services are not medically necessary (2)

\_\_\_\_\_ Preauthorization was not completed (3)

\_\_\_\_\_ Other (ask for details!) (4)  
\_\_\_\_\_

How do I submit an appeal (fax, letter, etc.)?  
\_\_\_\_\_

What is the address/number?  
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What do I need to submit in my appeal?

\_\_\_\_\_ Copy of claim/EOB

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\_\_\_\_\_

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# NATIONAL STUTTERING ASSOCIATION



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