

Insurance Coverage for Mental Health Services

It is important for you to understand how your insurance covers **mental health services** for your child or teen. Coverage may be different than **medical services**.

What is different about coverage for mental health services?

Some insurance companies cover mental health services the same as medical services. Others cover these services using a special mental health insurance company. Also, the number of mental health visits covered by your insurance may be different than the number of medical visits covered.

Which provider visits at Children's are billed as mental health visits?

Visits with a psychologist, psychiatrist, psychiatric nurse practitioner, mental health therapist, or behavioral consultant are billed as mental health services.

What should I ask the Psychiatry Clinic about insurance coverage?

Our Psychiatry Clinic can tell you if Children's is contracted with your insurance company for mental health services. Contracted means we have an agreement with them to cover these services.

If Children's is not contracted with my insurance for mental health services, what do I do?

If we do not have a contract, this means we are "out-of-network." You will need to find a provider who accepts your insurance.

What questions should I ask my insurance company?

Here are questions you can ask your insurance company to learn more about your child's mental health coverage.

- How many visits are allowed per year?
- Can my child see any provider, or do I have to choose from a list?
- Does our insurance plan limit services to in-network providers?
- Are the providers at Children's Department of Psychiatry and Behavioral Medicine in-network? Here's information your company may need to answer this question:
 - Types of providers your child may see at Children's: psychiatrist, psychiatric nurse practitioner, psychologist, mental health therapist, or behavioral consultant
 - See the most "**Common Procedure Billing Codes**" on the next page.

Common Procedure Billing Codes

- Psychiatric Diagnostic Evaluation:
90791 or 90792
- New Patient Evaluation and Management: level 4 or 5 (99204-99205)
- Individual Therapy:
90834 (for 45-minute sessions)
- Group Therapy: 90853
- Multiple Family Group Psychotherapy (for parent groups):
90849
- Family Psychotherapy without patient:
90846

Common Diagnosis Billing Codes

- Unspecified Disruptive Behavior Disorder, Impulse-Control, and Conduct Disorder:
F91.9
- Attention Deficit Hyperactivity Disorder:
F90.2
- Autism Spectrum Disorder:
F84.0

- Is authorization required for services? If yes, what happens if visits are not authorized?
- Are there any diagnoses that are not covered? Are these diagnoses covered? (See “**Common Diagnosis Billing Codes**” to the left.)
- Clinic visits at Children’s are billed as an “outpatient hospital visit” instead of an “office visit.” How will my insurance cover this type of visit?

Will I be billed a facility charge?

You will be billed a facility charge for a mental health clinic visit only when you visit a psychiatrist or nurse practitioner for a medical checkup or to manage your child’s medicines.

A facility charge includes hospital expenses for a clinic visit that are separate from the cost of the medical provider. The facility charge includes costs for running the “facility” like supplies, equipment, exam rooms and other Seattle Children’s hospital staff.

Visit www.seattlechildrens.org/clinics-programs/billing/ for more information.

You will receive a separate charge from your medical provider for their services.

How does it work when my child is covered under more than one insurance plan?

Insurance regulations determine which coverage you need to use first. This is called primary insurance.

If your primary insurance does not cover care because the provider is not in-network, then the second insurance will not cover the care either. This is because you are expected to get care from a provider who is in-network with your primary coverage.

What if my child has Medicaid (Washington Apple Health)?

Washington Apple Health (formerly called Medicaid or Healthy Options) **will not** cover care denied by the primary insurance.

If your child is covered by Washington Apple Health, they must see a provider contracted with the Regional Support Network (RSN) in their county. Our Psychiatry and Behavioral Medicine Department is only contracted with the **King County** RSN. Your child can only get care outside of the RSN if they don’t meet the criteria to be seen in the RSN.

What if I want to pay out of pocket and not use my Medicaid (Washington Apple Health) so my child can come to Children’s?

We **cannot** do this. Children’s is a contracted provider with Medicaid and cannot accept payment from a family whose child is covered by them.

To Learn More

- Call your insurance company at the phone number listed on the back of your insurance card.
- Psychiatry and Behavioral Medicine
206-987-2164,
option 8

Free Interpreter Services

- In the hospital, ask your child's nurse.
- From outside the hospital, call the toll-free Family Interpreting Line 1-866-583-1527. Tell the interpreter the name or extension you need.

Definitions:

Authorization: Many insurance companies or company they hire have to review and approve (authorize) the patient's care plan before they agree to pay for services. We request authorizations from insurance companies after visits are scheduled.

Coinsurance: Your share of the fee for a covered service. Some plans have both a copay and coinsurance, and some have only one.

Copay (also called copayment): The fee you pay at the time of service (most often for an office visit or a hospital stay). Copays don't apply toward a deductible or coinsurance maximum.

Deductible: The amount you pay each year before your plan will pay. Not all services go toward the deductible. This means that your plan will pay for some services even if you haven't met the deductible.

In-network coverage: Your plan covers your care from a provider who is contracted by your insurance company. It is best for you to use in-network coverage. Most times it has a lower deductible, lower copay, and more visits allowed per year.

Out-of-network coverage: Covers your care from a provider who is not contracted by your insurance company. We don't recommend you use out-of-network coverage. Most times it has a higher deductible, higher copay and/or coinsurance, and limited visits per year. Many plans do not offer out-of-network coverage.