PATHWAY CLINICAL GROUP

PATIENT EDUCATION

Out-of-Network Reimbursement

A working guide for outpatient mental health care

START HERE

This guide explains common steps for seeking reimbursement when you voluntarily use an out-of-network outpatient mental health clinician. It cannot predict payment. Your plan documents, applicable law, and the plan's written claim decision control.

Before you begin

Out-of-network billing can feel uncertain because several separate decisions determine your cost: whether the service is covered, whether the clinician is eligible, the plan's allowed amount, your deductible and coinsurance, and whether you file correctly and on time. Verify these points before care when possible.

This guide is not the right map for every situation. Emergency care, care at a participating hospital or facility, air ambulance services, Medicare, Medicaid/Medi-Cal, HMO or EPO coverage, and plan-authorized exceptions may follow different rules. See "Special situations" below.

What "out of network" means

An in-network clinician has a contract with your plan. Your cost may be a copay, deductible, coinsurance, or a combination. An out-of-network clinician has no network contract with the plan. The clinician sets the billed charge; the plan applies its own coverage terms and allowed amount. The clinician may require payment at the time of service.

If the claim is covered, the plan may pay you or the clinician, depending on the plan and any assignment of benefits. A superbill helps document the service, but it does not guarantee coverage or payment.

IMPORTANT COST WARNING

For ordinary elective care with a clinician you knowingly choose out of network, you may owe the full billed charge. The amount above the plan's allowed amount may not count toward a deductible or out-of-pocket maximum. Federal surprise-billing protections usually do not convert a voluntary private-office visit into an in-network claim. [1, 6, 8]

The six-step process

1. Confirm the exact benefit and rules.
2. Learn the numbers that affect your cost.
3. Get the documents your plan requires.
4. Submit promptly and track the claim.
5. Correct errors or appeal a denial.
6. Check special rules for your coverage and situation.

Step 1 — Confirm what your plan covers

Call the member-services number on your insurance card and also review your Summary of Benefits and Coverage, Evidence of Coverage, Summary Plan Description, or certificate of insurance. Ask for answers in writing when possible. A benefit quote is not a guarantee of payment.

Questions to ask

- Do I have out-of-network benefits for outpatient mental health or behavioral health?
- Is this clinician type covered, and must the clinician meet any licensure, credentialing, or enrollment rule?
- Is the service covered? Ask about individual, family, couples, group, and telehealth services separately.
- Do I need prior authorization, a referral, or a single-case/network-gap agreement before treatment?
- What is my out-of-network deductible, and how much remains?
- What is my coinsurance? What percentage does the plan pay after the deductible?
- What is the allowed amount for the likely CPT code in my location? Does the plan use UCR, a fee schedule, a percentage of Medicare, or another method?
- Does the plan have a separate out-of-network out-of-pocket maximum? Do charges above the allowed amount count?
- Are there visit limits or other treatment limits? How are they applied under mental-health parity rules?
- Which claim form and supporting documents are required? Is a superbill enough, or is a member claim form or CMS-1500 required?
- What is the exact claim-filing deadline? When does the clock start?

- Who receives payment—the member or provider? Does an assignment of benefits change that?
- How do I appeal, what is the deadline, and what external-review process applies?

Step 2 — Understand the numbers

> **RECORD THE CALL**
>
> Write down the date and time, representative's name, reference number, and answers. Save screenshots, portal confirmations, letters, and plan messages.

Four core terms

1. Billed charge: The clinician's fee.
2. Allowed amount: The maximum amount on which the plan bases payment for a covered service. If the charge is higher, you may owe the difference. [6]
3. Deductible: The eligible amount you must pay before the applicable benefit begins to pay. In-network and out-of-network deductibles may be separate. Only amounts recognized under the plan count.
4. Coinsurance: Usually your percentage of the allowed amount after the deductible. Ask the plan to state both your share and the plan-paid share.

What "UCR" means

UCR means "usual, customary, and reasonable." HealthCare.gov defines it as an amount based on what providers in a geographic area usually charge for the same or similar service. A plan may use UCR to set the allowed amount, but not every plan does. "UCR" is not one universal public price. [7]

Example

Assume a $200 billed charge, a $140 allowed amount, no deductible remaining, and 40% member coinsurance. The plan-paid share is 60% of $140, or $84. The member's net cost is $116: $56 coinsurance plus the $60 charge above the allowed amount. If $100 of the deductible remained, the plan would first apply $100 of the allowed amount to the deductible and then apply coinsurance to the remaining $40. This is an illustration only.

OUT-OF-POCKET MAXIMUM

The ACA out-of-pocket limit is primarily an in-network protection. HealthCare.gov states that premiums, noncovered services, out-of-network care, and amounts above the allowed amount do not count toward that limit. A plan may separately track out-of-network spending; verify your plan. [8]

Mental-health parity

For plans subject to the federal Mental Health Parity and Addiction Equity Act, financial requirements and treatment limits for mental-health or substance-use-disorder benefits generally cannot be more restrictive than comparable medical/surgical limits. If a plan offers out-of-network medical/surgical benefits, parity rules may require comparable out-of-network mental-health benefits. Parity does not guarantee a particular reimbursement rate or eliminate all coverage rules. [9]

Current-rule note: federal agencies announced in May 2025 that they would not enforce new provisions of the 2024 parity final rule while litigation and reconsideration continue, plus 18 months after a final decision. Earlier regulations and statutory parity duties remain in effect. [10]

Step 3 — Get the required claim documents

A superbill is an itemized statement from the clinician. It can support a claim, but it may not be the claim itself. Follow your plan's instructions; some plans require a member claim form, a CMS-1500 professional claim form, or additional records. [18]

Common superbill information

- Patient name, date of birth, member ID, and address if required.
- Clinician or practice name, address, phone number, tax identification number, and National Provider Identifier (NPI).
- Rendering clinician's name and credentials; license information if the plan requests it.
- Each date of service listed separately.
- Place-of-service code, including the correct telehealth setting when applicable.
- Clinician-selected CPT/HCPCS procedure code and units.
- Clinician-selected ICD-10-CM diagnosis code when required.
- Billed charge, amount paid, and payment status.

- Clinician signature or attestation if required by the plan.

Common psychotherapy coding conventions include 90791 for a psychiatric diagnostic evaluation, 90834 for 38–52 minutes of psychotherapy, and 90837 for 53 minutes or more. Other codes may apply. The clinician—not the patient—must select codes that accurately describe the service and documentation. [23]

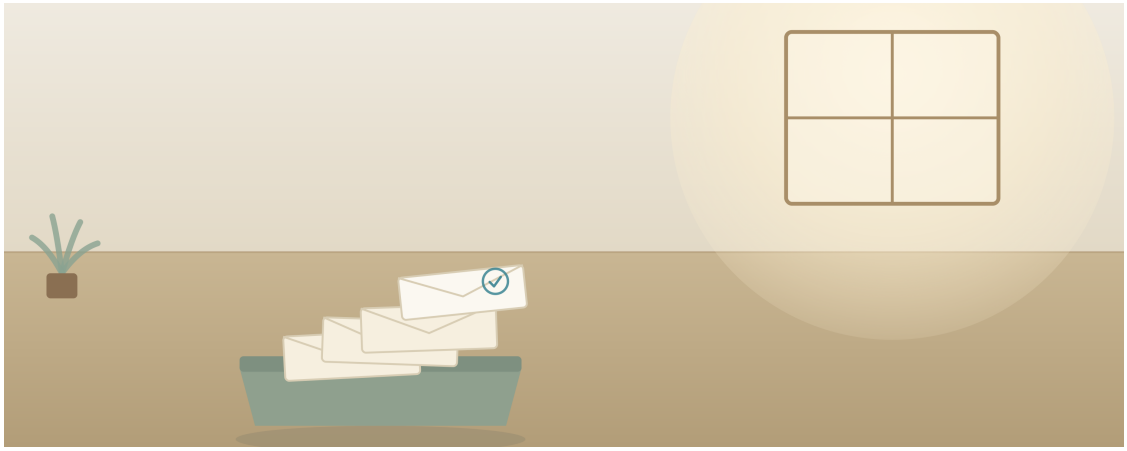
PRIVACY AND DIAGNOSIS CODES

A claim generally sends health information to the plan so it can decide payment and conduct plan operations. Ask the clinician and plan what information is required and review their privacy notices. Do not ask a clinician to omit or change an accurate diagnosis or procedure code. If a claim could affect a separate legal, employment, security, disability, or insurance matter, obtain advice appropriate to that situation before deciding whether to submit.

Couples and family services are not uniformly covered. Coverage may depend on the plan, the service's purpose, the covered member, the diagnosis, the coding, and the medical-necessity rules. Verify the specific service and code before care.

Step 4 — Submit and track the claim

1. Use the submission method in the plan's instructions.
2. Include every required form and attachment. Keep a complete copy.
3. Save the portal confirmation, fax transmission report, or postal tracking.
4. Record date of service, date submitted, claim number, and outcome.
5. Respond promptly to requests for more information.
6. Read the explanation of benefits (EOB). An EOB is not a bill. Compare billed charge, allowed amount, deductible, coinsurance, plan payment, denial reason, and payee with your records.



Deadlines

The claim-filing deadline is set by your plan and may be shorter than expected. Ask for the exact deadline and submit promptly. A late-filing denial may still be appealable, but approval is not guaranteed.

For many employer group health plans governed by ERISA, a post-service claim generally must be decided within a reasonable time and no later than 30 days. A plan may extend up to 15 days for reasons beyond its control if it gives timely notice; time can also be affected when more information is requested. These federal timing rules do not describe every plan. [4]

Step 5 — Correct or appeal a denial

A denial is not automatically final. Read the denial notice and EOB. The plan must explain the reason and how to appeal. First determine whether the problem is a correctable submission error, a coverage exclusion, lack of authorization, provider eligibility, coding, medical necessity, or another issue.

1. Call for the exact denial reason, code, and plan provision. Take notes.
2. Correct a clerical or missing-information problem using the plan's resubmission process.
3. For a substantive denial, file a written internal appeal by the stated deadline. Identify the claim, explain why the denial should be changed, cite the plan language, and attach supporting records.
4. If medical necessity is disputed, ask the treating clinician whether a clinical statement or records are appropriate. Do not submit altered or inaccurate information.
5. If the internal appeal is denied, read the notice for external-review rights and deadlines. External review is available only for eligible issues; not every payment or contract dispute qualifies. [5]

For many ERISA-governed group health plans, members must receive at least 180 days to file an internal appeal, and a post-service appeal generally must be decided within 60 days. Other plan types and state rules may differ. Use the deadline in your notice. [4]

What the 2024 denial data do—and do not—show

KFF's analysis of 2024 HealthCare.gov qualified health plans found that 37% of out-of-network claims were ultimately denied, compared with 19% of in-network claims. The data combined medical and prescription claims and did not identify mental-health services. The reported appeal rate of less than 1% and roughly one-third reversal rate applied to in-network denied claims, not specifically to out-of-network mental-health claims. [19]

No Surprises Act: when it helps

The federal No Surprises Act generally limits cost sharing and balance billing for most emergency services, certain non-emergency services from out-of-network providers at participating hospitals, hospital outpatient departments, and ambulatory surgical centers, and out-of-network air ambulance services. State law may provide additional protection. [1]

It generally does not protect a routine visit when you knowingly choose an out-of-network clinician in a private office. Ground ambulance services are generally outside the federal surprise-billing protections. Never delay emergency care to check network status.

The federal independent dispute resolution (IDR) process is mainly for payment disputes between plans and providers or facilities involving protected items and services. It is not the ordinary appeal route for a patient seeking reimbursement for voluntarily chosen out-of-network office care. [2]

Step 6 — Special situations

Uninsured or self-pay: good faith estimates

If you are uninsured or choose not to use insurance, federal rules generally require a provider or facility to give a written good faith estimate after you schedule care within specified timeframes and when you request one. If a provider's billed charges are at least $400 more than that provider's estimate, you may qualify for the federal patient-provider dispute process; deadlines apply. [3, 24]

If you plan to use insurance, ask the clinician for a fee estimate and the plan for benefit information, but do not assume the uninsured/self-pay federal dispute process applies.

Medicare

For Original Medicare, a participating provider accepts Medicare assignment. A non-participating provider remains in Medicare, may accept assignment case by case, and is often subject to a limiting charge. Providers generally submit claims for Medicare-covered services. [11]

A clinician who has formally opted out may use a private contract. For services covered by that contract, neither you nor the clinician submits the service to Medicare and Medicare does not pay; special rules apply to emergency or urgent care. Medicare Advantage plans have their own network and authorization rules. Verify the clinician's status and your plan before care. [11, 12]

Medi-Cal or another Medicaid plan

Do not assume a private-pay superbill will be reimbursed. Coverage, authorization, network, and private-payment rules vary by program, plan, provider status, and service. Enrolled providers generally may not bill members beyond permitted cost sharing for covered services. Contact the plan before scheduling. For improper billing involving Medicare/Medi-Cal dual eligibility, DHCS advises members not to pay first and to seek help. [13]

HMO or EPO with no routine out-of-network benefit

Routine elective out-of-network care may be excluded. Exceptions can include emergency care, plan-authorized care, continuity-of-care rights, or a network-access remedy when the plan cannot provide timely appropriate care. Ask the plan for an in-network option and, if needed, how to request authorization or file a network-access complaint.

California help

For many California HMOs and health-care service plans regulated by the Department of Managed Health Care (DMHC), first file a grievance with the plan. If you disagree with the decision or 30 days pass without a decision, you can contact DMHC; urgent problems may be eligible for immediate help. DMHC complaints can address billing and claim disputes. Independent Medical Review (IMR) is for qualifying medical-necessity, experimental/investigational, and emergency-payment issues and is free to the enrollee. [14, 15]

- DMHC Help Center: 1-888-466-2219 · https://www.dmhc.ca.gov/FileaComplaint.aspx

The California Department of Insurance (CDI) regulates many PPO and other insurance policies and handles complaints about covered products. [16]

- CDI Consumer Hotline: 1-800-927-4357 · https://www.insurance.ca.gov/01-consumers/101-help/

Self-funded employer plans are generally regulated federally under ERISA rather than by California insurance agencies. Ask the employer or plan administrator whether the plan is self-funded; the U.S. Department of Labor's EBSA can provide benefits-rights assistance.

- EBSA: 1-866-444-3272 · https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa

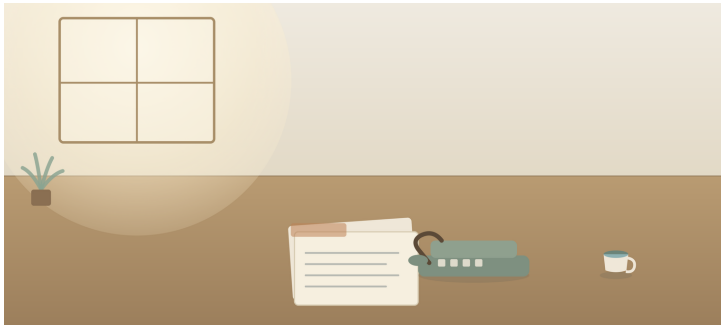
Paying with an HSA or FSA; tax deduction

Qualified mental-health treatment can be a medical expense for federal tax purposes. HSA and FSA eligibility still depends on the account's rules, the purpose of care, and documentation. An expense cannot be reimbursed twice by insurance and a tax-advantaged account. Keep receipts and EOBs, and ask the account administrator if uncertain. [17]

For a federal itemized medical-expense deduction, only qualified unreimbursed expenses above 7.5% of adjusted gross income are potentially deductible, subject to IRS rules. This guide does not provide tax advice. [17]

If the cost does not work

- Ask whether the practice offers reduced-fee appointments; availability and eligibility vary.
- Ask the plan for in-network clinicians who are accepting new patients and the expected appointment time.
- If the network cannot provide timely appropriate care, ask how to request a network-gap or single-case agreement and how to file a network-access complaint.
- Use 211 to identify local counseling, community clinics, and practical-support resources. Availability varies by location. [22]
- Ask universities or training clinics about supervised lower-cost services.
- Check whether an employee assistance program offers short-term counseling.
- Ask a licensed clinician whether group therapy or another format is clinically appropriate; do not choose a service only because it is cheaper.



Worksheet — Benefits call sheet

Member services number: _____ Date/time: _____

Representative: _____ Reference number: _____

☐ Do I have out-of-network benefits for outpatient mental health or behavioral health?

☐ Is this clinician type covered, and must the clinician meet any licensure, credentialing, or enrollment rule?

☐ Is the service covered? Ask about individual, family, couples, group, and telehealth services separately.

☐ Do I need prior authorization, a referral, or a single-case/network-gap agreement before treatment?

☐ What is my out-of-network deductible, and how much remains?

☐ What is my coinsurance? What percentage does the plan pay after the deductible?

☐ What is the allowed amount for the likely CPT code in my location? Does the plan use UCR, a fee schedule, a percentage of Medicare, or another method?

☐ Does the plan have a separate out-of-network out-of-pocket maximum? Do charges above the allowed amount count?

☐ Are there visit limits or other treatment limits? How are they applied under mental-health parity rules?

☐ Which claim form and supporting documents are required? Is a superbill enough, or is a member claim form or CMS-1500 required?

☐ What is the exact claim-filing deadline? When does the clock start?

☐ Who receives payment—the member or provider? Does an assignment of benefits change that?

☐ How do I appeal, what is the deadline, and what external-review process applies?

Notes: _____

_____

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_____

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Worksheet — Claim checklist and log

☐ Plan's claim form completed

☐ Superbill or CMS-1500 attached if required

☐ Patient and member information checked

☐ Clinician/practice identifiers checked

☐ Dates, place of service, procedure codes, diagnosis code, charges, and payment status checked

☐ Supporting records attached only if requested or relevant

☐ Submission deadline confirmed

☐ Complete copy saved

☐ Proof of submission saved

DATE OF SERVICE	DATE SUBMITTED	HOW SENT	CONFIRMATION / CLAIM NO.	OUTCOME / NEXT DEADLINE

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References:

- [1] CMS — No Surprises Act consumer rights: https://www.cms.gov/newsroom/fact-sheets/no-surprises-understand-your-rights-against-surprise-medical-bills
- [2] CMS — Federal Independent Dispute Resolution: https://www.cms.gov/initiatives/no-surprise-billing/overview/engaging-idr/about-independent-dispute-resolution
- [3] CMS — Patient-provider payment dispute resolution: https://www.cms.gov/initiatives/no-surprise-billing/overview/policies-resources/providers-payment-resolution-patients
- [4] U.S. Department of Labor/EBSA — Filing a Claim for Your Health Benefits: https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/filing-a-claim-for-your-health-benefits
- [5] HealthCare.gov — Appealing an insurance-company decision: https://www.healthcare.gov/appeal-insurance-company-decision/appeals/
- [6] HealthCare.gov — Allowed amount: https://www.healthcare.gov/glossary/allowed-amount/
- [7] HealthCare.gov — UCR definition: https://www.healthcare.gov/glossary/ucr-usual-customary-and-reasonable/
- [8] HealthCare.gov — Out-of-pocket maximum: https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/
- [9] U.S. Department of Labor — Mental-health parity overview: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity
- [10] U.S. Departments — 2024 parity-rule enforcement statement: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/statement-regarding-enforcement-of-the-final-rule-on-requirements-related-to-mhpaea
- [11] Medicare.gov — Assignment, non-participating providers, and opt-out: https://www.medicare.gov/basics/costs/medicare-costs/provider-accept-Medicare
- [12] CMS — Medicare Benefit Policy Manual, Chapter 15: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.PDF
- [13] California DHCS — Balance billing: https://www.dhcs.ca.gov/individuals/the-facts-on-balance-billing/
- [14] California DMHC — How to file a complaint: https://www.dmhc.ca.gov/FileaComplaint.aspx
- [15] California DMHC — Complaint and IMR FAQs: https://www.dmhc.ca.gov/FileaComplaint/FrequentlyAskedQuestions.aspx
- [16] California Department of Insurance — Surprise medical bills: https://www.insurance.ca.gov/01-consumers/110-health/60-resources/nosuprisebills.cfm
- [17] IRS Publication 502 — Medical and Dental Expenses: https://www.irs.gov/publications/p502
- [18] CMS — Professional paper claim form (CMS-1500): https://www.cms.gov/medicare/coding-billing/electronic-billing/professional-paper-claim-form
- [19] KFF — Claims Denials and Appeals in ACA Marketplace Plans in 2024: https://www.kff.org/patient-consumer-protections/claims-denials-and-appeals-in-aca-marketplace-plans-in-2024/
- [20] RTI — Behavioral health in-network access report: https://www.rti.org/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf
- [21] 988 Suicide & Crisis Lifeline: https://988lifeline.org/
- [22] 211 — Local community resources: https://www.211.org/
- [23] CMS Medicare Coverage Database — Psychiatric evaluation and psychotherapy coding: https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=57520&LCDId=33252&DocID=L33252
- [24] CMS — Good faith estimate guide: https://www.cms.gov/medical-bill-rights/help/guides/good-faith-estimate
- [25] CMS — No Surprises Act consumer advocate toolkit: https://www.cms.gov/nosurprises/consumer-advocate-toolkit

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