# PRO-ACT

# Frequently Asked Questions

## What are your office hours?

Our business office is open from 9 AM until 4 AM Monday through Thursday, and 9 AM until noon on Friday.

Our therapists see clients **by appointment only** during the hours of 8 AM - 8 PM, Monday - Thursday and 8 AM - 5 PM Friday but none of our therapist offer appointments at all of those hours.

We can often accommodate unusual schedules and even make home visits when needed.

## I'm a Christian, do you offer Christian Counseling?

All of the counselors at PRO-ACT are Christians and counsel from a Christian worldview.  We pride ourselves in providing counseling that is both cllinically competent and theologically sound.

## How do I make an Appointment

Prospective new clients should call **713-475-0072** to speak with an intake worker who will gather needed information and make the necessary arrangements with the insurance company (if required). Your information will then be passed to a therapist who provides the kind of services you need, and is on your insurance plan . The therapist will then contact you directly to schedule your initial appointment. Except in very unusual circumstances, you will be seen within 2 or 3 days and in urgent situations within a few hours.

## What are your fees?

PRO-ACT is a private business. This is what we do for a living. Our fees are comparable to those charged by others in our profession. We can provide information about available community based services for those with limited

ability to pay, and we often have interns who see clients at substantially reduced rates.

Our counselors are licensed by the State of Texas and have been in practice up to 15 years or more. Our fee for these counselors is $150.00 for an assessment, $120.00 for followup individual sessions, and $140.00 for family sessions. Your insurance may cover all or a part of these fees.

If you have chosen an HMO or PPO plan, we would have to determine if we have a contract with the plan that you have chosen. There are more plans than you can imagine and it is impossible for us to be contracted with all of them. We are on most of the major plans. Occasionally these counselors are willing to establish a payment plan to allow you to pay for their services over time.

## Will You take my Insurance?

We are often asked, "Do you take my insurance?" We understand what you want to know, but a better way to put it is "Will your insurance pay PRO-ACT for the services you need?" This question in turn has two parts: "Will your insurance pay for the services you need?", and "Will your insurance pay our clinician to perform the services?" The only way to find out is to call your insurance company and ask. We are happy to make the call for you, and, if you are covered, we will bill the insurance company for their part. In all cases, you are ultimately responsible for payment of our fees.

Generally insurance plans treat mental health coverage (sometimes called Mental/Nervous) differently from general medical coverage, including different limits, co-pays and other restrictions.

## Usual and Customary (U&C)" or "Reasonable and Customary (R&C)" Fee

These are similar to a list price or a 'rack rate' at a hotel. It is the fee charged when there is no contract that calls for a different fee. For a fee for service plan, an insurance company may determine the prevailing rate for a particular service in a particular area and use that as the basis for reimbursement.

## Practitioner restrictions.

Under Texas law if a medical plan provided by an **insurance company** covers a particular treatment or procedure, it must pay for that procedure do be performed by any class of provider licensed by the state to do so. The difficulty is that so called 'self funded' benefit plans are exempt from this law and some continue to restrict mental health coverage to Psychiatrists, Psychologists, and Licensed Social Workers. In most cases this is a throwback to the days when these were the only trained and licensed mental health providers, or a national plan is following Medicare rules.

## What is pre-certification and when is it required?

Most of the PPO and HMO plans require that all treatment be approved by them beforehand. This is done by phone. We can usually do this for you, but some plans require the member to call personally.

## Do you take CHIP and Medicaid?

CHIP is a fairly new program that covers children who's families do not qualify for Medicaid but do not have other medical coverage. The mental health part of the program is administered through several contractors who in turn contract with a network of providers, very much like an HMO or PPO. We have providers on two of the CHIP plans: ChoiceOne (Magellan) and Texas Children's (CompCare).

Medicaid provides mental health coverage for children in families whose incomes fall below the federal poverty level. Medicaid offers both a traditional freedom of choice plan and several HMO plans. One of our providers sees medicaid clients, but has very limited availability.

## I’m on Medicare. Can you see me?

Medicare restricts mental health providers to Psychiatrists (MD), Psychologists (Ph.D.), and Licensed Social Workers (LMSW). None of our therapists are Medicare providers. See our Credentials page for more information about categories of providers.

## What is a ‘Carve Out’?

One of the complications of dealing with insurance companies in the mental health area is that many of them manage mental health services differently than they do all other care. Mental health, often combined with substance abuse. is

considered a specially field that requires a special network of providers and special skills to manage. Therefore, many insurers subcontract (carve out) the management of those services to one of a number of companies who specialize in the field. Thus, we usually cannot determine our network status for a particular person's coverage by knowing the name of the insurance company, since the company may use more than one mental health subcontractor depending on the plan chosen by the member or offered by the employer.

## What is a provider Panel and which ones are you on?

All 'Managed Care' plans (HMO, PPO, and EAP) maintain contracts with a group of providers called a network or panel. Often the plans limit the number of providers in their network in order to control the cost of maintaining the network as well as to provide a reasonable number of referral to the providers.

Unfortunately, network maintenance is not an exact science and the plan may be woefully out of touch with the number of active providers they might have serving a particular geographic area. Plans may still list providers who have moved away or who are no longer in practice at all. In the Houston area, many plans seem not to realize that a provider in 'Houston' may be an hour away from a person seeking a referral. Yet in many cases these same plans will not accept additional providers into their networks. Some networks in the Houston area have been closed to new providers for more than five years.

## What is an EAP?

Employee Assistance Plans provide very short term care (2 - 5 visits), usually at no cost to the member. These plans are intended to be evaluation and referral programs.

## What is the difference between traditional insurance, HMO’s, PPO’s and POS plans?

There are several types of insurance plans which cover mental health treatment.

"Traditional", "Casualty", or "Fee for Service" plans.

These plans were the original health insurance plans, but are rare today. They pay either a fixed fee for a particular service or a percentage of the "Usual and Customary" (U&C) fee charged by a provider. These plans

usually pay regardless of who performs the service, although they may restrict the class of practitioners for whose services they will pay. You are generally responsible for the difference between the insurance payment and the U&C fee, as well as any deductible amount.

Many of these plans will cover PRO-ACT services.

HMO plans.

Based on the idea that maintaining health is more economical than treating illness, Health Maintenance Organizations (HMOs) were created in an attempt to contain rising health care costs. HMOs contracts with groups (usually employers or unions) to provide all health care for their members at a fixed cost per person. The HMO then enlists health care providers to provide the health care services at a "contract rate" that is usually lower than the U&C fee. The members of the group get any needed care from these contracted providers and usually pay only a small co-pay regardless of the service needed. HMOs generally provide preventative care that is not usually covered by casualty plans. The contracted providers are called a 'network' and all treatment must be performed by 'in network' providers in order to be covered. HMO care is often provided by large clinics and chains of related clinics who employ the various practitioners to actually perform the services. Consumers usually have little or no choice of providers, and out of network services are covered only in very rare circumstances (e.g. emergency treatment).

HMOs are the most restrictive (in terms of provider selection) of all insurance plans, and in many cases will not cover PRO-ACT services. However, your HMO may use one of the networks our counselors are associated with. Give us a call and we will find out for you.

PPO plans.

Preferred Provider Organizations are a compromise between traditional plans and HMOs. PPO plans maintain contracts with 'Preferred Providers' who offer services to plan members at reduced rates, but members are generally free to seek care from any qualified provider (out of network). Deductibles are usually higher and reimbursement rates lower for out of network care. Most PPOs are 'managed' plans, which means that care must be approved ('authorized' or 'certified'} in advance and the number of covered visits is limited.

POS Plans.

Point of Service plans are HMO like plans with Primary Care Physicians controlling most care, but have some out of network benefits.