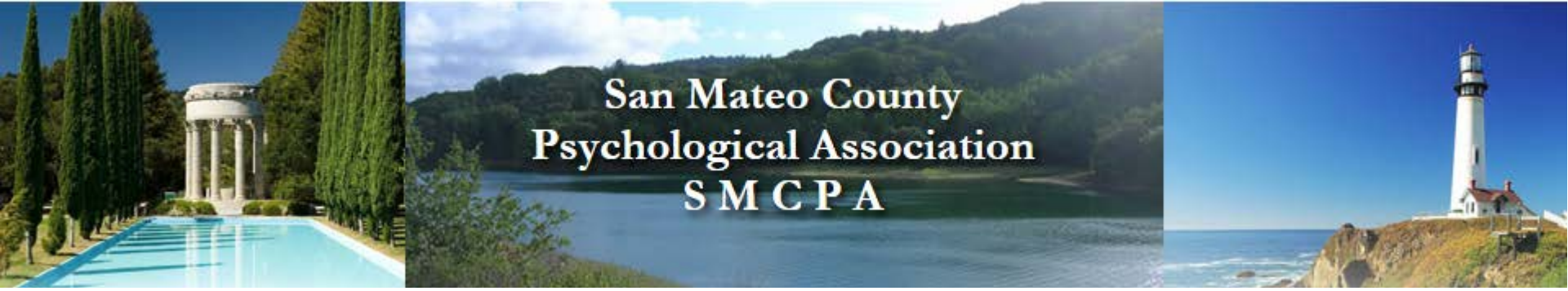
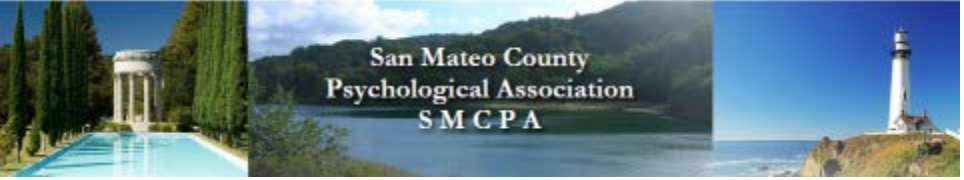


Managing Managed Care and Insurance in Private Practice

Larry Feinstein, PhD

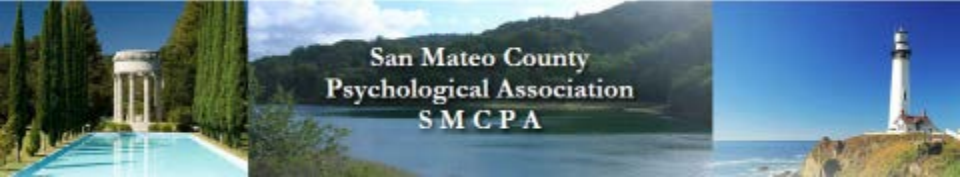
June 10, 2017



4 LEARNING OBJECTIVES / AGENDA

1. Develop a coherent, clinically-sound case conceptualization to use in a collaborative case review, from intake assessment and intervention, through progress review and termination

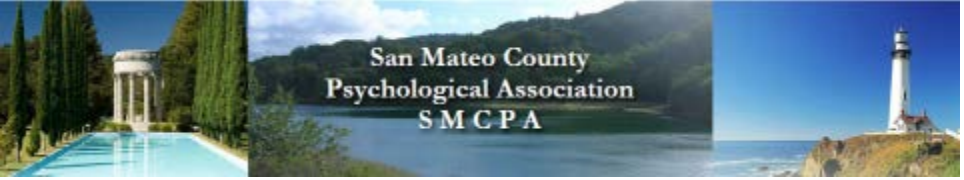
2. Comply with the regulations and ethical requirements of private insurance and Medicare, including dual-eligible coverage



4 LEARNING OBJECTIVES / AGENDA

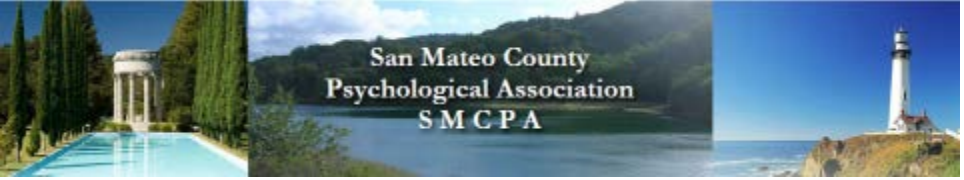
3. Analyze whether taking insurance payments, billing insurance, and/or being on managed care panels is right for your practice

4. Assess whether practice management billing software or a billing service is right for you



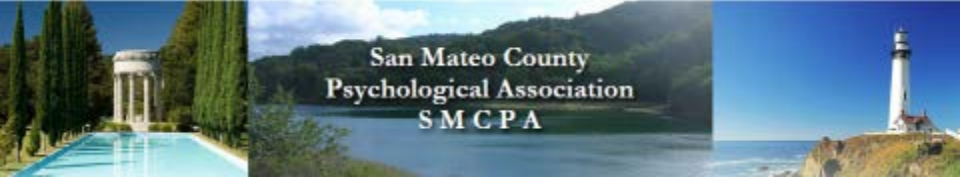
VOCABULARY … *and Assumptions*

1. Insurance Company
2. Managed Care Organization (MCO)
3. TPA (Third Party Administrator)
4. Insurance Benefit
5. Coverage Plan
6. Insured, Dependent
7. Insurance Premium



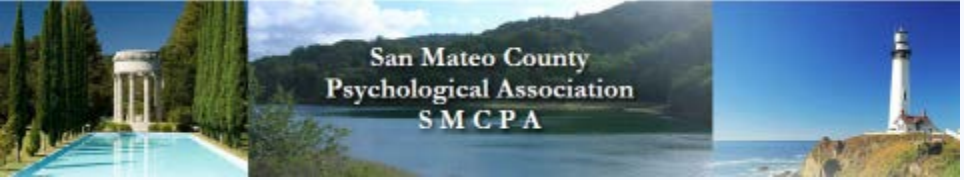
VOCABULARY … *and Assumptions*

8. Deductible, Co-Payment, Co-Insurance
9. Coordination of Benefits
10. Secondary Coverage, Dual-eligible (Medi-Medi)
11. Provider Panel / Network
    In-Network, Out-Of-Network (OON)
    Credentialing
12. Medical Necessity, and Medical Necessity Criteria



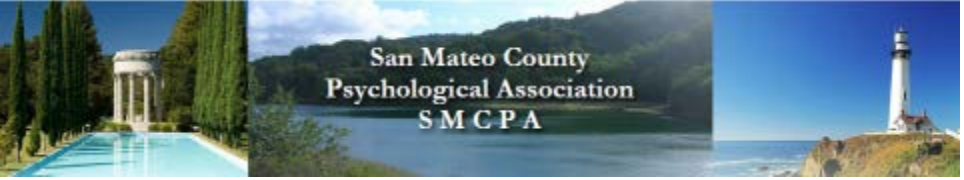
VOCABULARY … *and Assumptions*

13. Level of Care, Duration of Care, CPT Code
    Examples: 90791, 90834, 90837, 90847, 90853, 90901
14. Electronic Claims Submission
    Claims Clearinghouse (Examples: OfficeAlly, Gateway EDI)
15. EOB: Explanation of Benefits
    ERA: Electronic Remittance Advice
16. Denial, Reprocessing, and Appeal
17. Single-case Contract, Medical Director Approval
18. Repricing

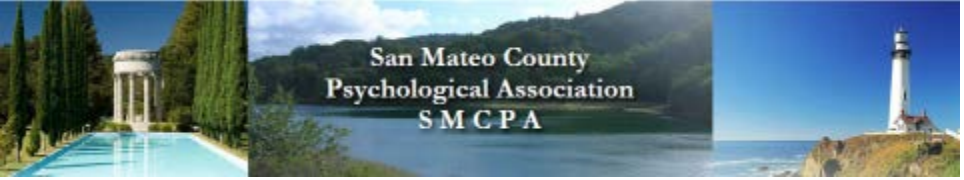


LEARNING OBJECTIVE 1

1. Develop a coherent, clinically-sound case conceptualization to use in a collaborative case review, from intake assessment and intervention, though progress review and termination, that enables you to demonstrate that you meet the payer's medical necessity criteria.



What is a "Medical Necessity" ?

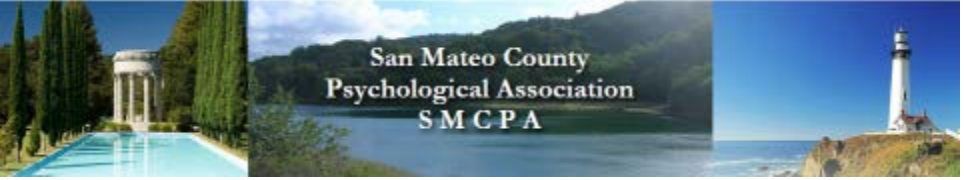


Medical Necessity Criteria

Magellan defines Medical Necessity as:

Services by a provider to identify or treat an illness that has been diagnosed or suspected. The services are:

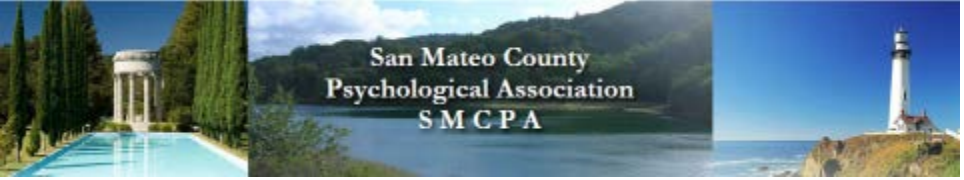
1. Consistent with:
   a) the diagnosis and treatment of a condition; and
   b) the standards of good medical practice;
2. Required for other than convenience; and
3. The most appropriate supply or level of service. When applied to inpatient care, the term means: the needed care can only be safely given on an inpatient basis.



New Directions Behavioral Health defines Medical Necessity as:

… healthcare services rendered by a provider, exercising prudent clinical judgment, which are:

A. Consistent with:
   1. The evaluation, diagnosis, prevention, treatment or **alleviation of symptoms** of an illness, disease or injury defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM).
   2. Generally accepted standards of medical practice, as defined by credible scientific evidence published in peer-reviewed medical literature, which are generally recognized by the appropriate medical community, Physician Specialty Society recommendations and other relevant factors.
B. Clinically appropriate with regard to type, frequency, extent, site, and duration of services to meet the individualized needs of the patient.
C. Reasonably expected to improve symptoms associated with the patient's illness, disease, injury or deficits in functioning.
D. The least restrictive and most appropriate service or level of care to safely, effectively, and efficiently meet the needs of the patient.
E. Required for reasons other than the convenience of the patient, family/support system, physician or other healthcare provider.
F. Not a substitute for non-treatment services addressing environmental factors.
G. Not more costly than alternative service or services that are at least as likely to produce equivalent diagnostic or therapeutic results for the patient's illness, disease or injury.



2008 UBH/PBH/USBHPC Level of Care Guidelines: Mental Health Outpatient

Outpatient care consists of visits provided in an ambulatory setting for the purpose of assessing and treating a mental health condition.

Any one of the following criteria must be met…

1. Clinical symptoms or behaviors caused by a covered behavioral health condition.
2. Impairment/deterioration in psychosocial functioning due to a behavioral health condition or psychological problem.
3. Behavioral health condition requiring psychotropic medication maintenance and monitoring.

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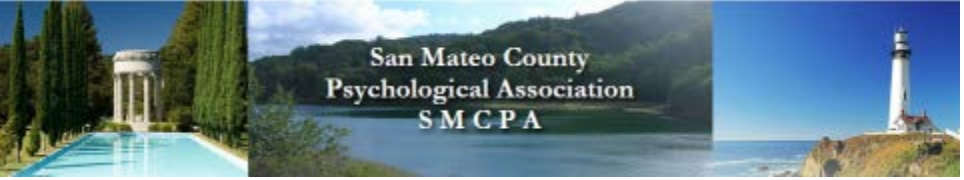
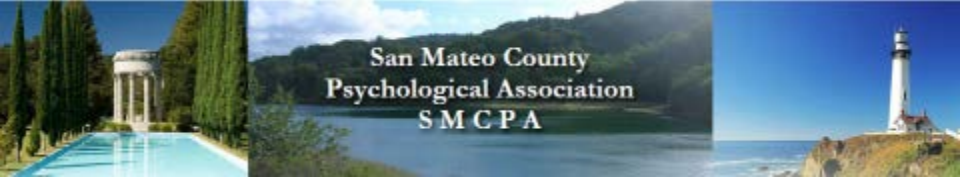


2008 UBH/PBH/USBHPC Level of Care Guidelines:
Mental Health Outpatient

And all of the following...

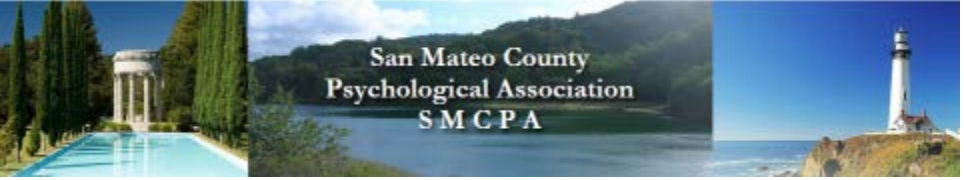
1. The member is not at imminent risk for harm to self or others.
2. The member exhibits adequate behavioral control to be treated in this setting.
3. Co-occurring Substance-Related Disorders, if present, are stable and are not unlikely to undermine treatment of the mental health condition at this level of care.
4. The provider and member set clear, reasonable, and objective treatment goals for the member's symptoms and diagnosis. Treatment goals should be jointly developed with the member whenever possible. If the member is a minor, treatment goals should be developed with the parent/guardian.
5. The frequency and duration of outpatient visits is required for a safe and timely achievement of treatment goals.
6. The treatment plan includes linkage and coordination with the appropriate professional and available community resources with the member's documented consent and where applicable (including the member's PCP) especially when there are multiple service providers.
7. For all members seen concurrently by a prescribing provider and a PhD/MA level provider there must be documented communication/coordination of care between the providers. Communication/coordination should allow the prescribing provider to make timely adjustments to the medication regimen. Communication/coordination of care between providers must be with the member's documented consent.
8. Where clinically indicated and with the member's documented consent, the member's family/social support system is actively participating in treatment. The family/support system will actively participate in the treatment of child and adolescent members on a regular ongoing basis except when clinically contraindicated.



2008 UBH/PBH/USBHPC Level of Care Guidelines: Mental Health OP - Termination

Any one of the following criteria must be met…

1. An appropriate termination plan with referral to appropriate and necessary community resources as required.
2. Refusal of treatment or repeated failures to comply with the recommended treatment. In such cases, the risks of discontinuing treatment are explained to the member and, as appropriate, the member's family/social supports, and alternative referrals are provided in writing.
3. Successful completion of treatment goals where the member agrees that treatment goals have been completed, and there is an appropriate termination plan.
4. Resolution or adequate reduction in clinical symptoms and behaviors that necessitated treatment as assessed by the provider.
5. Demonstration of sufficient improvement, and the ability to function adequately without any evidence of significant risk to self or others and without significant impairment in psychosocial functioning.
6. Psychotropic medication and monitoring for possible relapse is no longer required, or medications are stabilized well enough and the primary care physician has agreed to take over prescribing requirements.
7. Treatment is otherwise no longer medically necessary.



Magellan: Criteria for Authorizing Psychological Testing

Prior to psychological testing, the individual must be assessed by a qualified behavioral health care provider. The diagnostic interview determines the need for and extent of the psychological testing. Testing may be completed at the onset of treatment to assist in the differential diagnosis and/or help resolve specific treatment planning questions. It also may occur later in treatment if the individual's condition has not progressed and there is no clear explanation for the lack of improvement.

I. **Severity of Need**

Criteria A, B and C must be met:

A. The reason for testing must be based on a specific referral question or questions from the treating provider and related directly to the psychiatric or psychological treatment of the individual.

B. The specific referral question(s) cannot be answered adequately by means of clinical interview and/or behavioral observations.

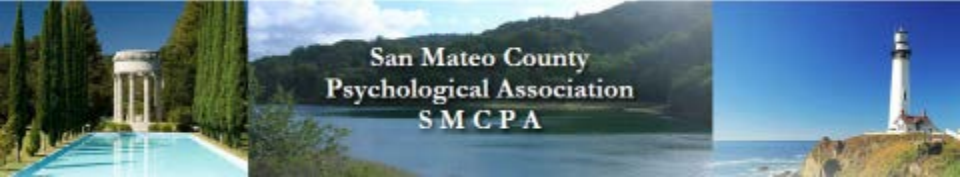
C. The testing results based on the referral question(s) must be reasonably anticipated to provide information that will effectively guide the course of appropriate treatment

II. **Intensity and Quality of Care**

Criteria A and B must be met:

A. A licensed doctoral-level psychologist (Ph.D., Psy.D. or Ed.D.), or other qualified provider as permitted by applicable state and/or federal law, who is credentialed by and contracted with Magellan, administers the tests.

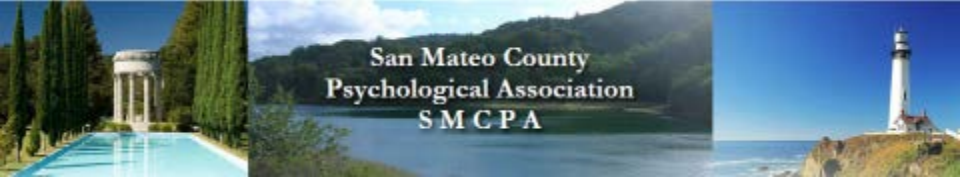
B. The requested tests must be standardized, valid and reliable in order to answer the specific clinical question for the specific population under consideration. The most recent version of the test must be used, except as outlined in Standards for Educational and Psychological Testing



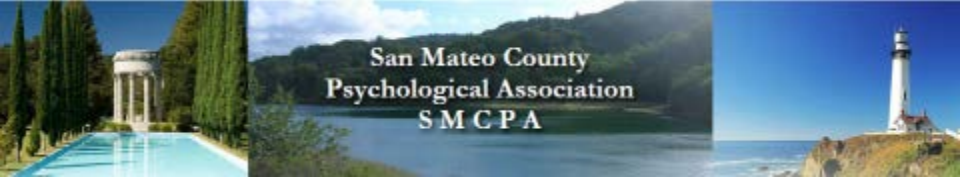
Magellan: Criteria for Authorizing Psychological Testing

III. **Exclusion Criteria:** Psychological testing will not be authorized under any of the following conditions:

A. The patient is not neurologically and cognitively able to participate in a meaningful way in the testing process.
B. The test is used as screening tool given to the individual or to general populations.
C. Administered for educational or vocational purposes that do not establish medical management.
D. Performed when abnormalities of brain function are not suspected.
E. Used for self-administered or self-scored inventories, or screening tests of cognitive function (whether paper-and-pencil or computerized), e.g., AIMS or Folstein Mini-Mental Status Examination.
F. Repeated when not required for medical decision-making (i.e., making a diagnosis or deciding whether to start or continue a particular rehabilitative or pharmacologic therapy).
G. Administered when the patient has a substance abuse background and any of the following apply:
    1. The patient has ongoing substance abuse such that test results would be inaccurate, or
    2. The patient is currently intoxicated.
H. The patient has been diagnosed previously with brain dysfunction such as Alzheimer's disease, and there is no expectation that the testing would impact the patient's medical management.
I. The test is being given solely as a screening test for Alzheimer's disease.
J. Unless allowed by the individual's benefit plan, the testing is primarily for the purpose of determining if an individual is a candidate for a medical or surgical procedure.
K. The testing is primarily for diagnosing attention-deficit hyperactivity disorder (ADHD), unless the diagnostic interview, clinical observations, and results of appropriate behavioral rating scales are inconclusive.
L. The testing is primarily for legal purposes, including custody evaluations, parenting assessments, or other court or government ordered or requested testing.
M. The requested tests are experimental, antiquated, or not validated.
N. The testing request is made prior to the completion of a diagnostic interview by a behavioral health provider, unless pre-approved by Magellan.
O. More than eight hours per patient per evaluation is considered excessive and supporting documentation in the medical record must be present to justify greater than eight hours per patient per evaluation.
P. Not applicable

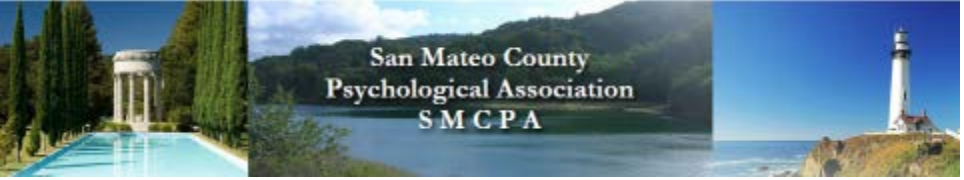


What is a "Case Conceptualization" ?



Case Conceptualization

1. Intake assessment:
   - Presenting complaint / issue(s)
   - Clinical history
   - Treatment history: failure at a lower level of care?
   - Resources: support network, support groups,
   - Coordination of Care with Psychiatrist, PCP, Specialists
   - Measures: Valid and reliable

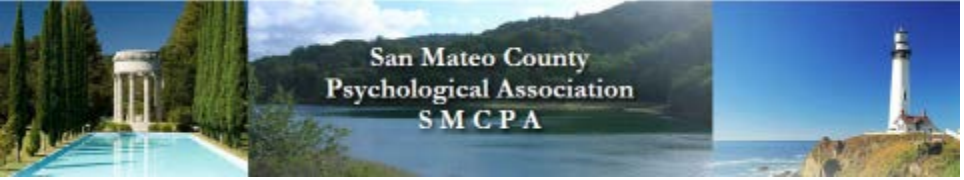


Case Conceptualization

2. Diagnosis, supported by symptoms

   or

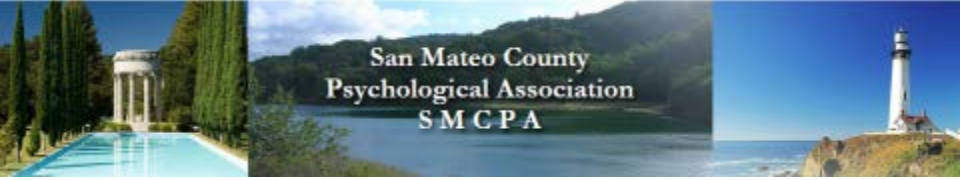
   Functional impairments



Case Conceptualization

3. Treatment Plan:
   - Goals
   - Objectives
   - Interventions
   - Expected duration
   - Criteria for termination

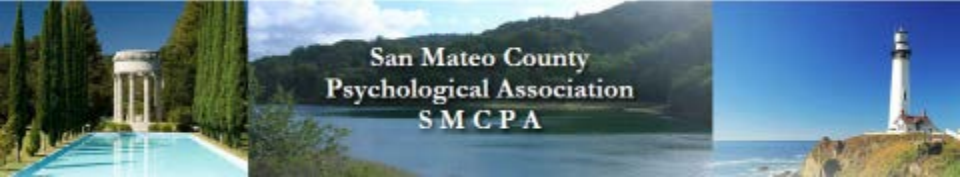
- Are your psychotherapy interventions evidence-based? Do they meet best practice guidelines?
- Are the goals and objectives measurable so you can assess progress or change interventions?



Case Conceptualization

4. Ongoing assessment to measure progress

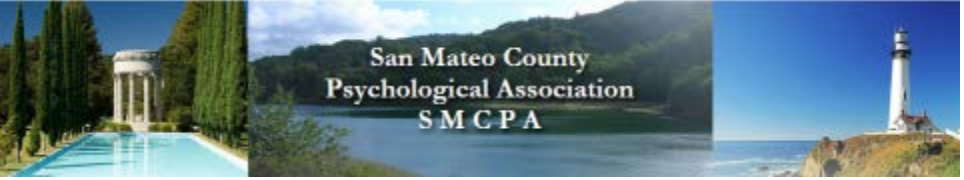
5. Criteria for tapering care or termination



Case Conceptualization

Assessment tool examples – Discussion

- UBH's Wellness Assessment
- PHQ9, Cigna
- Beck Depression Inventory (BDI)



Wellness Assessment

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

For questions 1-16, please think about your experience in the past week.

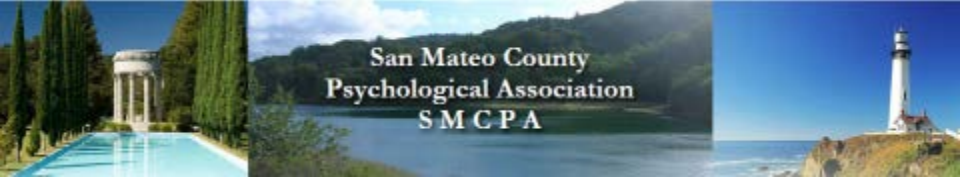
How much did the following problems bother you?	*Not at All*	*A Little*	*Somewhat*	*A Lot*
1. Nervousness or shakiness	○	○	○	○
2. Feeling sad or blue	○	○	○	○
3. Feeling hopeless about the future	○	○	○	○
4. Feeling everything is an effort	○	○	○	○
5. Feeling no interest in things	○	○	○	○
6. Your heart pounding or racing	○	○	○	○
7. Trouble sleeping	○	○	○	○
8. Feeling fearful or afraid	○	○	○	○
9. Difficulty at home	○	○	○	○
10. Difficulty socially	○	○	○	○
11. Difficulty at work or school	○	○	○	○

How much do you agree with the following?	*Strongly Agree*	*Agree*	*Disagree*	*Strongly Disagree*
12. I feel good about myself	○	○	○	○
13. I can deal with my problems	○	○	○	○
14. I am able to accomplish the things I want	○	○	○	○
15. I have friends or family that I can count on for help	○	○	○	○

16. In the past week, approximately how many drinks of alcohol did you have? ☐☐ Drinks

Please answer the following questions only if this is your first time completing this questionnaire.

17. In general, would you say your health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
18. Please indicate if you have a serious or chronic medical condition:
    ○ Asthma ○ Diabetes ○ Heart Disease ○ Back Pain or Other Chronic Pain ○ Other Condition
19. In the past 6 months, how many times did you visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? *(answer only if employed)* ☐☐ Days
21. In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? *(answer only if employed)* ☐☐ Days
22. In the past month have you ever felt you ought to cut down on your drinking or drug use? ○ Yes ○ No
23. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? ○ Yes ○ No
24. In the past month have you felt bad or guilty about your drinking or drug use? ○ Yes ○ No



PHQ9

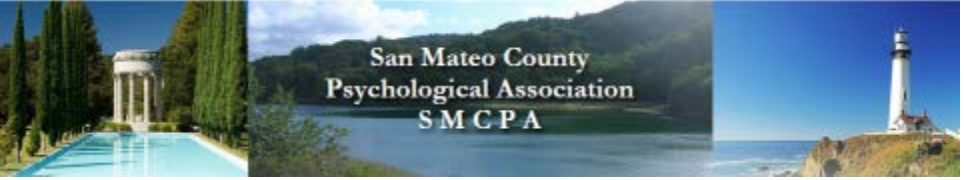
Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____



Beck (BDI, p1 of 2)

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

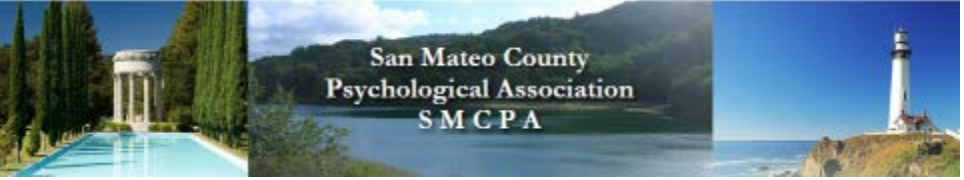
0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.



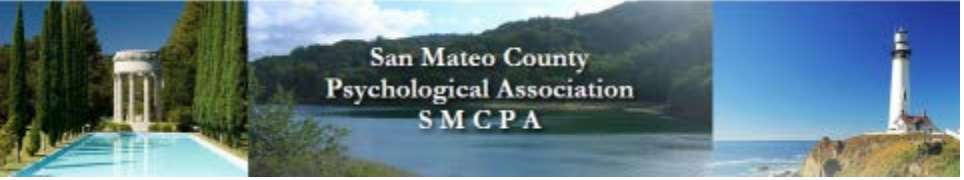
Case Conceptualization

Diagnosis - Discussion

- Diagnosis, supported by symptoms

or

- Functional impairments



Case Conceptualization

Diagnostic criteria for Generalized Anxiety Disorder (DSM-IV-TR)

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The person finds it difficult to control the worry

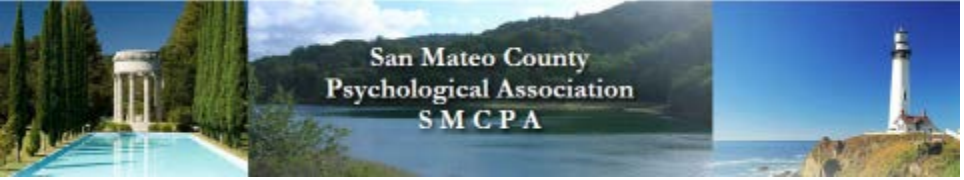
C. The anxiety and worry are associated with **three (or more) of the following six symptoms** (with at least some symptoms present for more days than not for the past 6 months):

   1) Restlessness or feeling keyed up or on edge
   2) Being easily fatigued
   3) Difficulty concentrating or mind going blank
   4) Irritability
   5) Muscle tension
   6) Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder

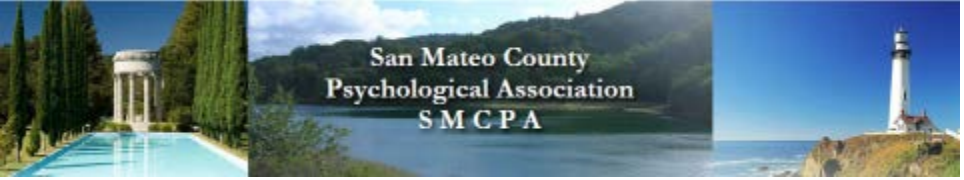


Case Conceptualization

FCAP: Functional Capacity Assessment Profile©

Instructions: This questionnaire consists of a list of activities and behaviors that are part of everyday living. Please read each one carefully, and then blacken in the circle that best describes **HOW ABLE ARE YOU TO DO THAT ACTIVITY DURING THE PAST 7 DAYS INCLUDING TODAY**.

	Are you able to…	Always	Almost Always	Most of the time	About half of the time	Some of the time	Almost Never	Never
	Emotional Management							
1	Reduce or manage stress	⓪	①	②	③	④	⑤	⑥
2	Calm yourself when you feel upset, angry, hurt, sad, depressed, nervous or panicky	⓪	①	②	③	④	⑤	⑥
3	Resolve conflicts with others	⓪	①	②	③	④	⑤	⑥
4	Express anger, hurt, or sadness without hurting others	⓪	①	②	③	④	⑤	⑥
5	Maintain a positive outlook on life and stay motivated	⓪	①	②	③	④	⑤	⑥
6	Maintain a positive self-image (good self-esteem)	⓪	①	②	③	④	⑤	⑥
7	Do things (such as travel or be in public) when you are afraid, or think you might panic	⓪	①	②	③	④	⑤	⑥
8	Stop an uncontrollable urge to do an unwanted behavior (e.g., eating, washing, spending)	⓪	①	②	③	④	⑤	⑥
9	Avoid doing things to purposefully hurt yourself (e.g., vomiting, over-dosing, cutting)	⓪	①	②	③	④	⑤	⑥
10	Stop yourself from emotionally or physically hurting others or damaging property	⓪	①	②	③	④	⑤	⑥
11	Stop yourself from doing mean, hurtful or illegal behaviors	⓪	①	②	③	④	⑤	⑥



Case Conceptualization

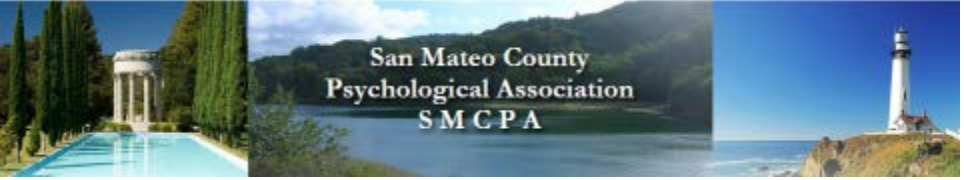
FCAP: Functional Capacity Assessment Profile©

7 Domains, 55 Items:

1. Emotional Management
2. Communication and Social Involvement
3. Health Behaviors
4. Personal Management
5. Leisure
6. Self-Care
7. Family Care
8. Job-Related

To use the FCAP, please contact Mark Mosk, PhD at DrMosk@Gmail.com

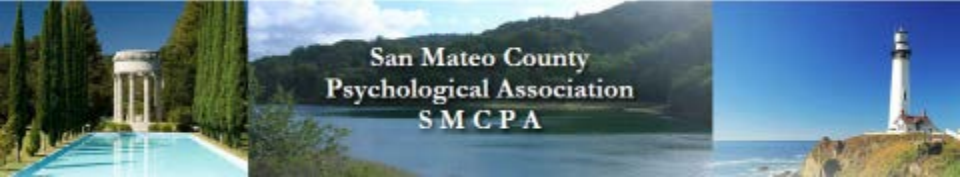
- Direct link between assessment and treatment plan: Issues are identified, prioritized, and sequenced. Can easily be repeated to document progress or need for continued treatment.



Case Conceptualization

Treatment Plan - Discussion

- For a patient with Generalized Anxiety Disorder, what are your treatment targets (possible causal factors, or factors that maintain the anxiety)?
- *What evidence-based interventions will you use? Are they considered "best practice"?*
- The case manager / auditor does not care what orientation you use; just that the payer's money is being used for an intervention that is evidence-based and likely to work (effective); thus, also measurable.



Treatment Plan – Discussion

Faxed to all providers, April 11, 2015

OPTUM™

ATTENTION: Optum Behavioral Network Practitioners and Clinical Staff

Best Practice for the Treatment of Depression and Bipolar Disorder

Optum adopted the American Psychiatric Association (APA) guidelines for the treatment of Major Depression and Bipolar Disorder. **Best Practice includes a treatment plan involving medication, therapy, self-empowerment/recovery tools, and collaboration among treating clinicians**.

Major Depression	Bipolar Disorder
Based on the APA guidelines and the National Committee for Quality Assurance antidepressant medication management HEDIS® specifications, Optum suggests that practitioners: ♦ Encourage adult patients diagnosed with Major Depression and started on antidepressant medication to **continue their prescribed medication(s) for at least six (6) months** ♦ Educate patients on the value of a full course of treatment, the risk for return of symptoms and their early recognition, and the importance of seeking treatment early	Based on the APA guidelines, and other scientific literature, Optum suggests that practitioners: ♦ Schedule at least **one medication management visit within 30 days of the initial diagnosis of bipolar disorder**, followed by three (3) medication management visits in the subsequent nine (9) months ♦ Encourage patients to **attend a minimum of two (2) psychotherapy visits within the first six (6) months** of the initial diagnosis

Clinicians are encouraged to complete as many sessions with patients as is clinically indicated.

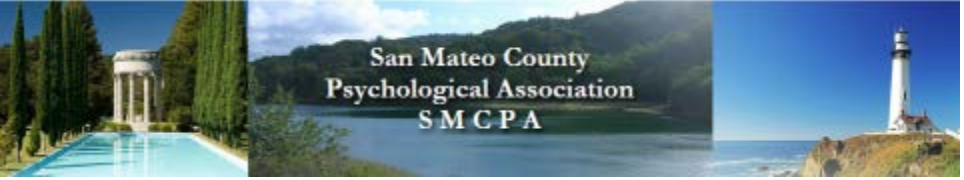
Suggestions for Medication Adherence and Recovery

- Encourage patients to continue treatment to prevent reoccurrence of symptoms and keep scheduled appointments
- Discuss with your patients possible medication side effects and how to deal with them
- Advise patients that it may take 10 to 12 weeks to experience the full effects of a medication
- Ask patients how their medication is working
- Remind patients to take their medication even if they feel better
- Encourage patients to allow exchange of information among their treating clinicians
- Remind patients that mental health issues can be successfully treated by adhering to their treatment plan

Resources For You and Your Patients

- providerexpress.com — Link to the APA Guidelines, a Clinical Toolkit for improving medication adherence, and patient materials
- liveandworkwell.com — Helpful patient resources and educational articles for Optum enrollees
- depressionprimarycare.org — Resources for practitioners, including the PHQ-9® for screening and monitoring depressive symptoms
- DBSAlliance.org — Depression & Bipolar Support Alliance

This information is provided by Optum's Quality Management and Improvement Department. We welcome your questions and feedback. If you would like to be removed from this distribution list you may contact us at: qmi_fax_mail@optum.com (email) or (855) 748-3908 (fax)

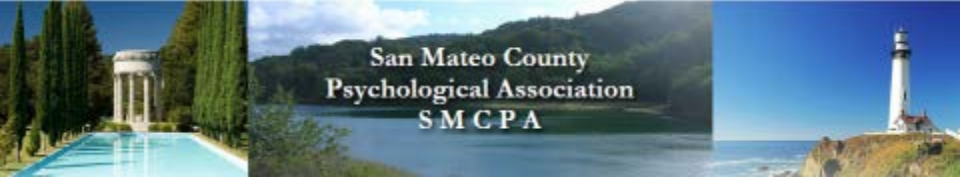


Case Conceptualization

Ongoing Assessment - Discussion

- Ongoing assessment to measure progress
- Criteria for tapering care or termination

Under what circumstances would long-term, ongoing, therapy meet necessity criteria?



Payer Audits

Traditional Commercial Health Insurance Audits

- Audit process:
  - Receipt of audit letter from insurance company demanding documentation
  - Usually a short time period for compliance with demand for documentation
  - Number of charts demanded and timeframe under scrutiny vary

From “Ethics & the Law: Complications in Communication With Clinical and Forensic Clients” by Jeffrey Younggren, PhD of the American Insurance Trust, 4/29/2017.

Traditional Commercial Health Insurance Audits

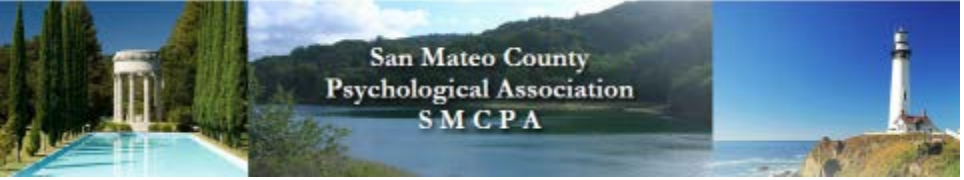
- Must the patient provide consent to the disclosure of the demanded records?
  - No. Patient has consented to insurance-company audit/oversight by signing up for insurance coverage and by signing the claim form.
- But how MUCH treatment information can be disclosed to the insurance company?
  - HIPAA Minimum Necessary Disclosure Rule

From "Ethics & the Law: Complications in Communication With Clinical and Forensic Clients" by Jeffrey Younggren, PhD of the American Insurance Trust, 4/29/2017.

Traditional Commercial Health Insurance Audits

- Preparation/Defense against these audits:
  - Good documentation evidencing adequate diagnosis and treatment
  - Well-organized charts
  - Periodic self-audit of your charts
  - Close monitoring of employees'/independent contractors' charting/billing
  - Citing the HIPAA Minimum Necessary Rule to challenge over-broad demands

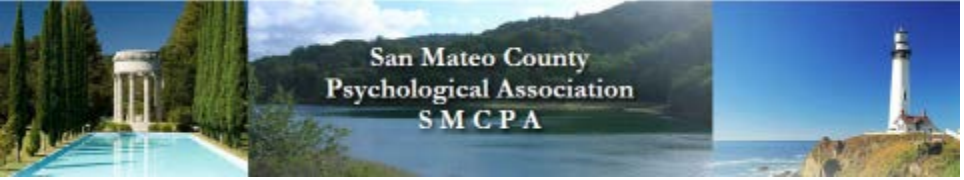
From "Ethics & the Law: Complications in Communication With Clinical and Forensic Clients" by Jeffrey Younggren, PhD of the American Insurance Trust, 4/29/2017.



Payer Audits

Why do payer audits happen?

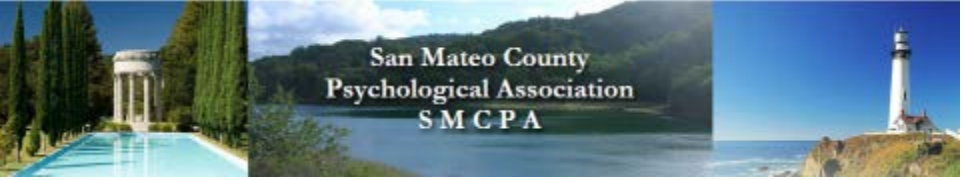
- Something you did tripped an alert inside the case management computer system, or …
- The payer does routine audits on all their providers



Payer Audits

The payer's computer is looking for fraud, waste, and abuse. Examples:

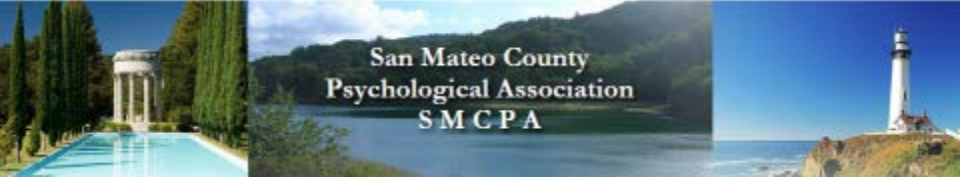
- Two sessions per week for a low intensity diagnosis; e.g., Social Phobia or Specific Phobia
- More than one session in a day (even by different providers; will trigger a denial)
- Too many sessions in a day (12+) or week (40+) (even with different patients)



Payer Audits

The payer's computer is looking for fraud, waste, and abuse. Examples:

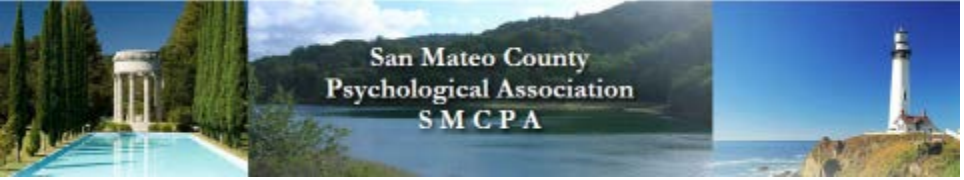
- Sudden increase in frequency of sessions
- Outpatient session while patient is in the hospital (they know by the claims)
- Same diagnosis for all patients
- Over-use of 90837



Payer Audits

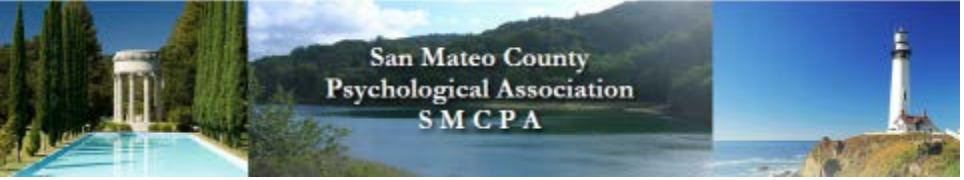
The payer's computer is looking for fraud, waste, and abuse. Examples:

- A diagnosis of Major Depressive or Bipolar Disorder with no services from a psychiatrist
- Medication typically used for Major Depressive or Bipolar Disorder with no services from a psychiatrist



Payer Audits – How to Respond

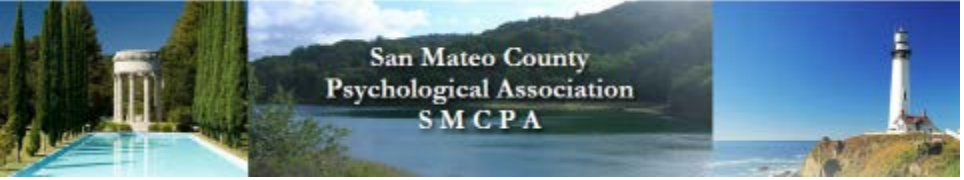
- Remain calm: You are more knowledgeable about the case than the reviewer
- Collaborate with the case manager or reviewer
- Be respectful of the fact that “your patient” is “their member”
- Be prepared to present a clinically-sound case conceptualization



Payer Audits – How to Respond

In a case review, you may be asked:

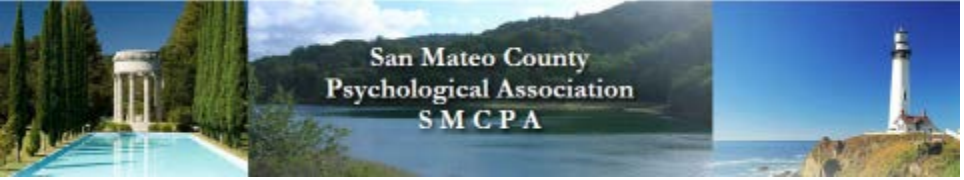
- Why is the patient still in treatment?
- How have you been measuring progress?
- What are your criteria for termination?
- How many more sessions will you need?
- What is the treatment intensity? That is, how many sessions per month does the patient require until you can reduce or terminate?



Payer Audits – How to Respond

In a case review, you may be asked:

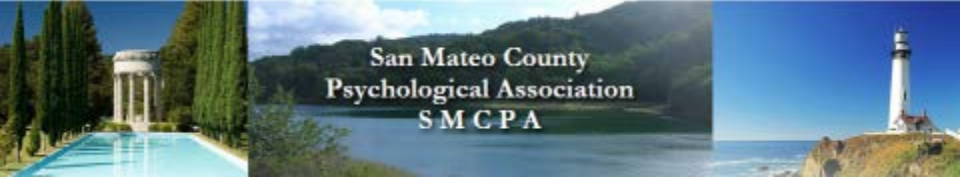
- If you assigned a major or parity diagnosis and the patient was not seeing a psychiatrist, did you refer to one?
- Have you been collaborating with the patient's psychiatrist or PCP?
- Have you consulted with the psychiatrist and reviewed the symptoms, diagnosis, and treatment plan?



Payer Audits – How to Respond

In a case review, you may be asked:

- Is the patient taking psych meds as prescribed by the psychiatrist? Can you document medication adherence (even if only patient report)?
- If the patient has a medical condition, have you contacted any specialty physicians?

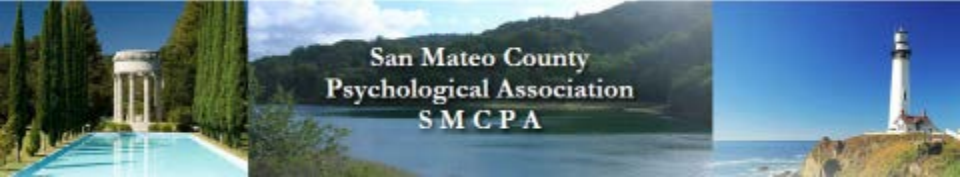


Payer Audits – How to Respond

Test your DSM knowledge:

- A diagnosis of Adjustment Disorder and weekly sessions are now in the 7th month

Can you defend ongoing treatment?



Payer Audits – How to Respond

Diagnostic criteria for Adjustment Disorders (DSM-IV-TR)

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).

B. These symptoms or behaviors are clinically significant as evidenced by either of the following:

   1) Marked distress that is in excess of what would be expected from exposure to the stressor

   2) Significant impairment in social or occupational (academic) functioning

C. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

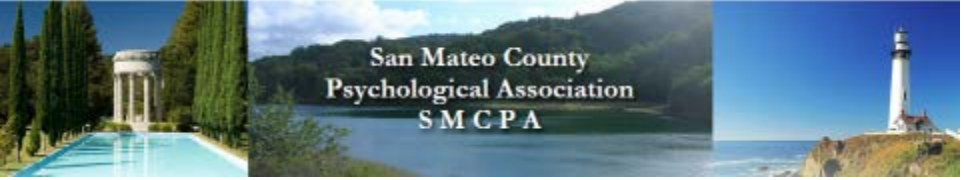
D. The symptoms do not represent Bereavement.

E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.

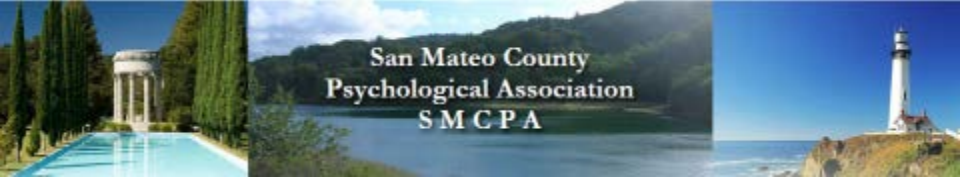
Specify if:

Acute: if the disturbance lasts less than 6 months
Chronic: if the disturbance lasts for 6 months or longer Adjustment Disorders are coded based on the subtype, which is selected according to the predominant symptoms.

The specific stressor(s) can be specified on Axis IV.

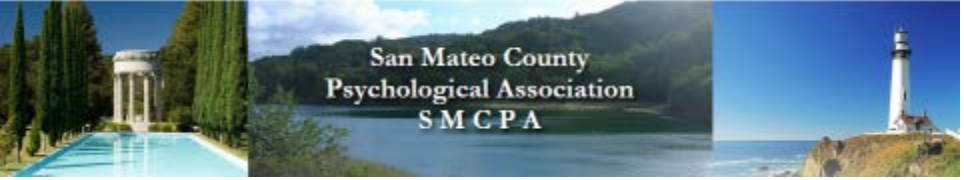


Payer Denials



Payer Denials

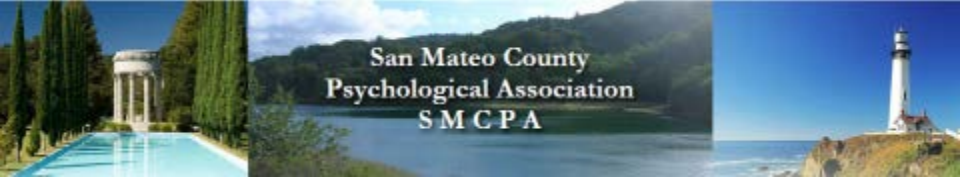
- Today, only BHRS and EAP companies are gate-keeping routine outpatient MH care using authorizations
- However, authorization is usually required for:
  - Specialty care (ABA autism)
  - Higher levels of care (IOP through IP)
  - Testing (psych, neuropsych)
  - Intensive care (3+ sessions per week, 2+ in one day)



Payer Denials

Call the payer and speak to Claims to find out why your claim was denied

- If it is a coding error, correct the error and resubmit the claim
- If it was a procedural error by the payer, request the claim to be reprocessed; examples:
  - Processed at in-network rate when you are out-of-network
  - Incorrect repricing (HealthNet has been doing this)



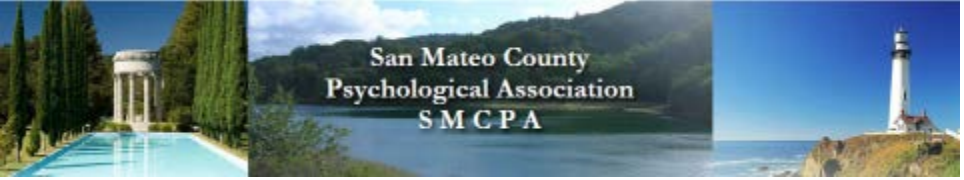
Payer Denials

Call the payer and speak to Claims to find out why your claim was denied

- If the patient lacks eligibility (e.g., coverage has not started yet, has expired, or is not included in the patients coverage plan), you can bill the patient directly.

  Do NOT alter the date on the claim to put it within the patient's eligibility date range; this is fraud.

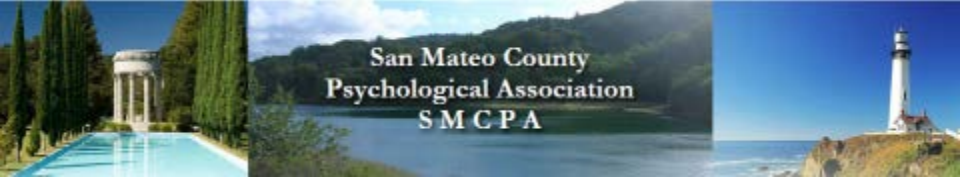
- If it is a clinical issue, request to do a case review



Payer Denials

In preparing for a clinical review, understand:

- To whom does the patient "belong":
  You or the payer?
- The payer's criteria for Medical Necessity, Level of Care, and Duration of Care
- Your "mission" in providing treatment

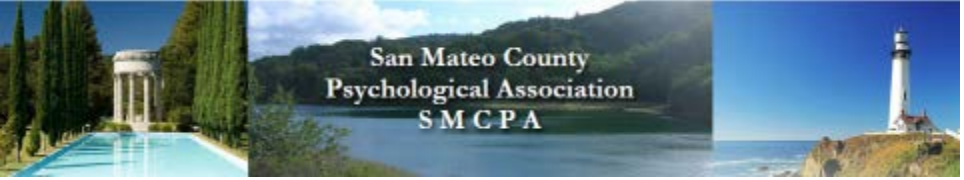


Payer Denials

Your mission in providing treatment:

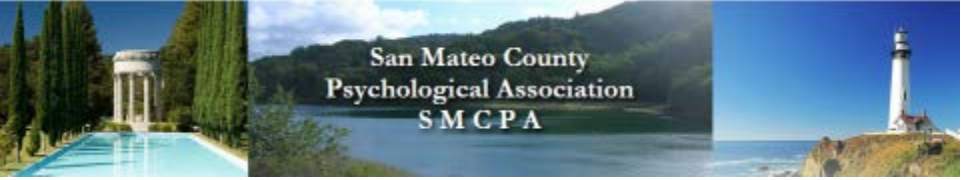
Ambulatory services are outpatient treatment services, provided by qualified mental health professionals and directed toward reversing symptoms of acute mental health disorders, and/or substance use disorders in order to facilitate improvement, maintain stability and increase functional autonomy for persons with various forms of mental health and substance use disorders. Outpatient services are specific in targeting the symptoms or problem being treated.

Your mission is NOT to make the patient happy or even well.



Payer Denials

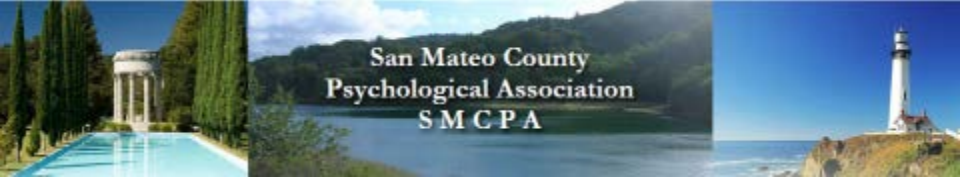
- Stay calm and collaborative
- The case manager is tasked to prevent fraud, waste, and abuse; and they see a lot of it
- Some case managers have good clinical skills, some do not
- Do NOT appeal to morality or what *should* be done for the patient.
- Focus on the patient's benefits, the payer's Medical Necessity Guidelines, and your knowledge of the case



Payer Denials

- Worth repeating: **Focus on the patient's benefits**
- The most common conflict between a case manager and a provider occurs because the patient purchased a Yugo and the patient or provider want a Lexus

  That is, the patient purchased a benefit plan that does not provide sufficient coverage, or has a deductible and/or copayment that is so high that s/he cannot afford care.

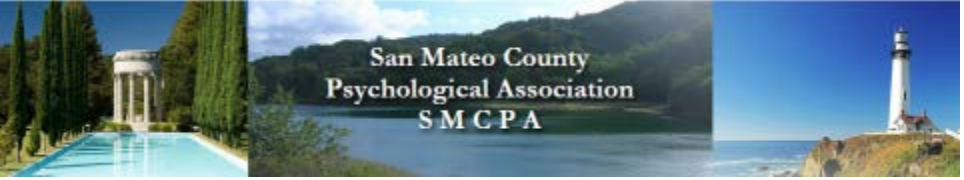


Payer Denials

Case Review

If the case manager disagrees with any part of your case conceptualization …

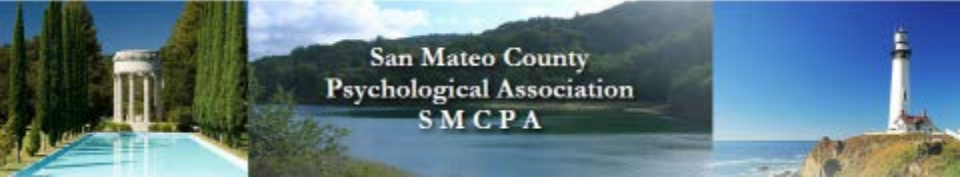
1. Don’t get defensive
2. Encourage him/her to explain
3. Receive the information as advice and offer to modify your treatment accordingly for an agreed upon period of time, and then do another review
4. If you believe the case manager is just wrong, be ready to support your position to a Medical Director with evidence and sources



Payer Denials

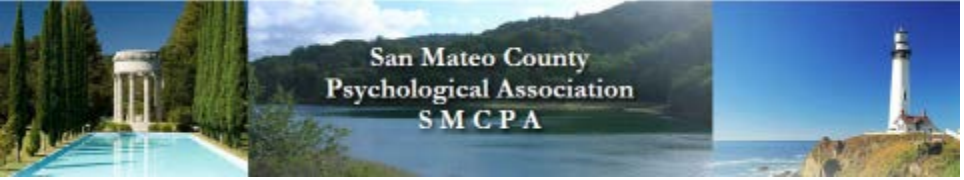
Escalation

- Escalate to a peer (PhD) reviewer
- Escalate to a Medical Director
- Go through the payer's 3-level appeals process
- Court litigation



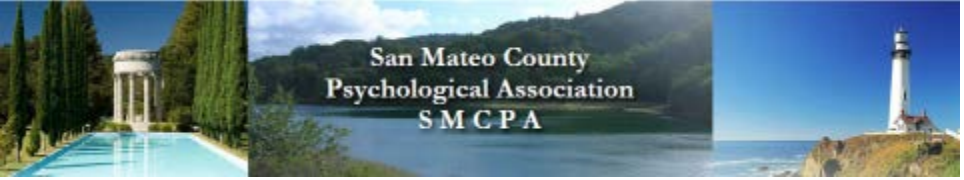
Payer Denials

- Keep careful records of your calls, reference numbers, and names of people you spoke with.
- Record special phone numbers and ways to get past the IVR.



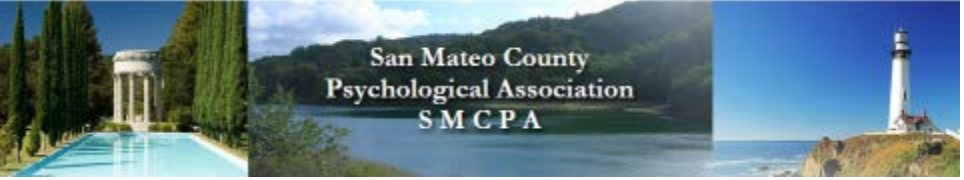
Payer Errors

- Stay calm, don't argue, remain effective, play to win by focusing on the issue
- Call Claims or Provider Relations:
  - Be ready for an IVR phone system from hell
  - If the representative seems to not know what s/he is doing, hang up and call back to get a different representative



Payer Errors

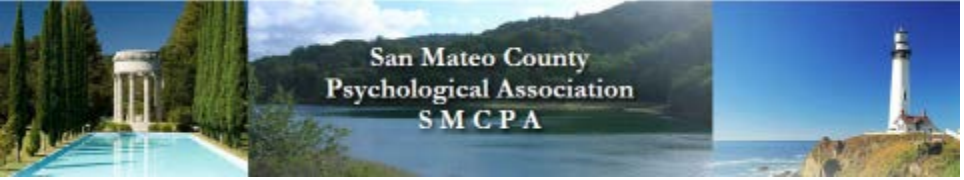
- Ask to speak to a supervisor. It may take a lot of time to get him/her on the phone, and the rep will try to convince you that you don't need to talk to the supervisor.
- If necessary, file a complaint with the payer. Be sure to provide full documentation.



Payer Errors

- As a last resort, file a complaint with the California Department of Managed Health Care (DMHC).
- They require that you first file a complaint with the payer
- Toll-free provider complaint line: 1-877-525-1295
- E-mail at pcu@dmhc.ca.gov
- Website: https://wpso.dmhc.ca.gov/provider/AllLogin.aspx

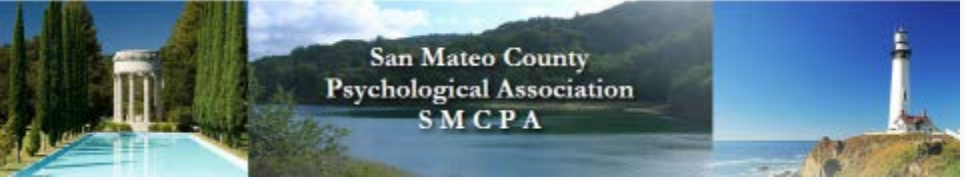
  You are required to create an account to use the DMHC Provider Complaint System.



Provider Complaints to DMHC by Health Plan, 2014

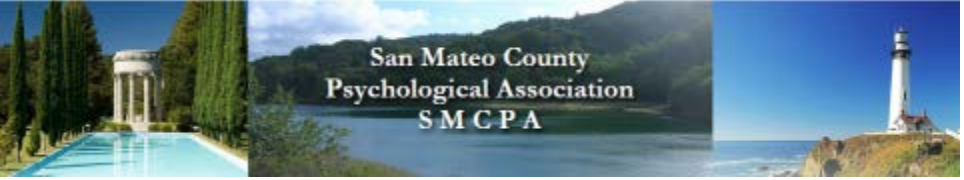
Note:
Anthem Blue Cross
and
Health Net of Calif

Health Plan	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Access Dental	2	5	4	1
Aetna Dental	0	0	4	0
Aetna Healthcare of CA	27	60	22	47
Blue Cross	185	176	405	245
Blue Shield	82	66	112	40
Bravo Health Insurance	0	0	0	0
California Health and Wellness	0	1	7	5
Care 1st Health Plan	32	38	52	117
Central Health Plan	1	0	1	0
Chinese Community Health Plan	0	1	0	0
Cigna Behavioral Health	1	0	1	1
Cigna HealthCare of California	8	9	11	13
Community Care Health Plan	3	0	0	0
Community Health Group	16	8	0	1
Contra Costa County Medical Service	0	1	3	0
County of Los Angeles- CHP	32	6	42	1
County of Ventura	0	0	2	1
Delta Dental of California	0	2	5	0
Easy Choice Health Plan	6	0	0	0
Health Net of California	149	69	202	211
Human Affairs International of CA	0	0	1	0
Inland Empire Health Plan	1	40	1	7
Inter Valley Health Plan	1	0	0	0
Kaiser Foundation Health Plan, Inc.	13	65	101	7
Kern Health Systems	0	0	1	0
Local Initiative Health Authority for L.A. County	7	23	3	21
L A Care Health Plan Joint Power Authority	93	8	40	73
Liberty Dental Plan	0	0	1	0
Magellan Health Services	2	1	1	15
Managed Health Network	1	6	7	0



LEARNING OBJECTIVE 2

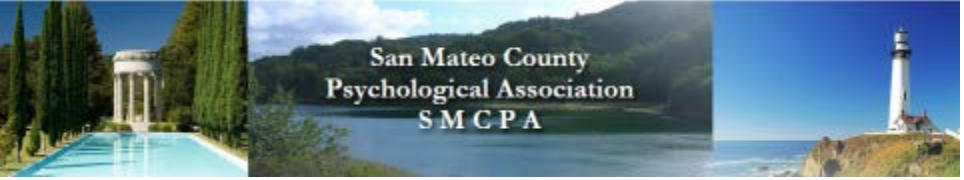
2. Comply with the regulations and ethical requirements of Medicare and private insurance, including dual-eligible coverage



Medicare Record Keeping

"Progress Notes" must include:

1. Start and stop time of each session
2. Patient's name at the top of each page
3. Date all entries
4. Sign all entries in the record with your name, degree, and other significant credentials

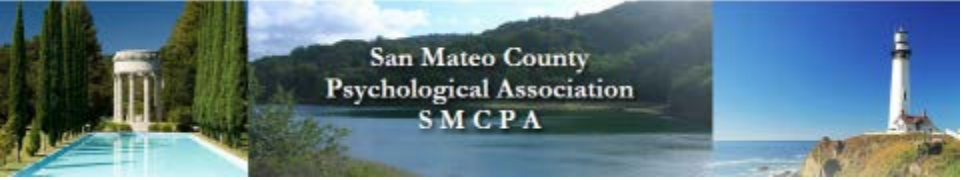


Medicare Record Keeping

"Progress Notes" should include:

5. Procedure provided and the CPT code
6. Medication info (unless noted elsewhere in the record)
7. Diagnosis with ICD or DSM Code, functional status, symptoms, prognosis, and progress to date
8. Closing or discharge summary

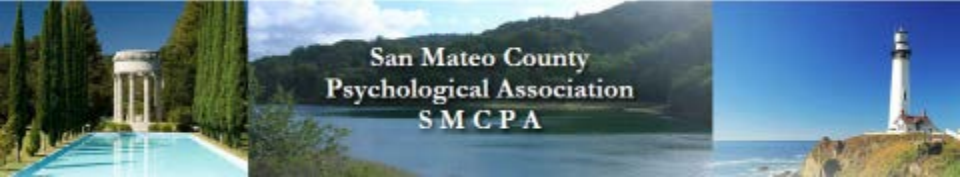
Progress notes are part of the medical record



Medicare Record Keeping

"Psychotherapy Notes" are …

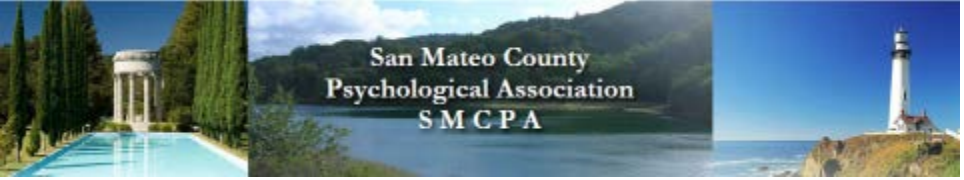
1. Maintained separate from the Medical Record
2. Notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session
3. Exclude everything in the previous two slides on Progress Notes



Medicare Record Keeping and HIPAA

"Psychotherapy Notes" are granted special protection under HIPAA due to the likelihood they contain particularly sensitive information, and also because they are the personal notes of the treating therapist— intended to help him or her recall the therapy discussion or session content.

A covered entity generally must obtain an authorization for disclosure of psychotherapy notes, or for use by a person other than the person who created the psychotherapy notes.

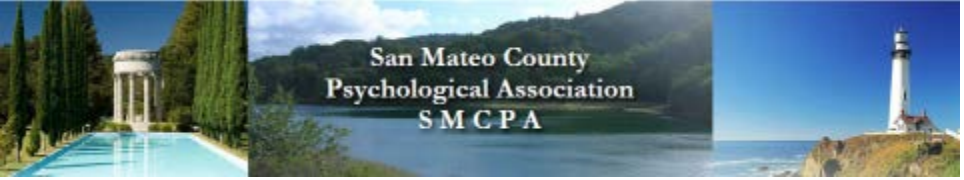


Medicare Billing Issues

In San Mateo County, some dual-eligible patients are enrolled in HPSM (Health Plan of San Mateo). They can ONLY receive care through BHRS.

For all dual-eligible patients in California,
Medi-Cal does not pay the Medicare copayment and does not allow providers to charge the copayment.

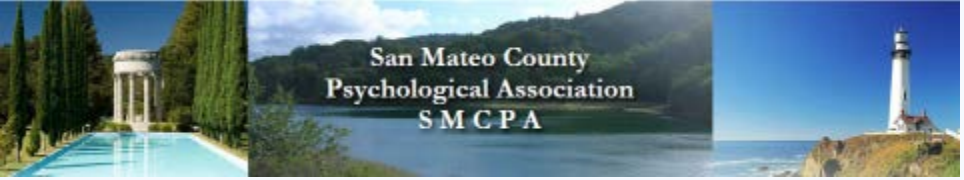
If you are not a Medicare provider, you cannot bill Medicare patients even if they say they will pay you out-of-pocket, unless you get a Medicare waiver (the patient has to “opt-out” of their Medicare benefit).



Compliance with Payer Regulations

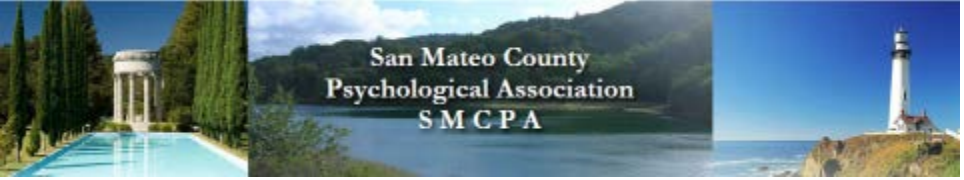
IMPORTANT: You cannot directly charge any member of a plan with which you are contracted. You must comply with the contract requirements and rates.

If you terminate a network contract, there is usually a 4-6 month waiting period before you are off the network and can charge patients directly.



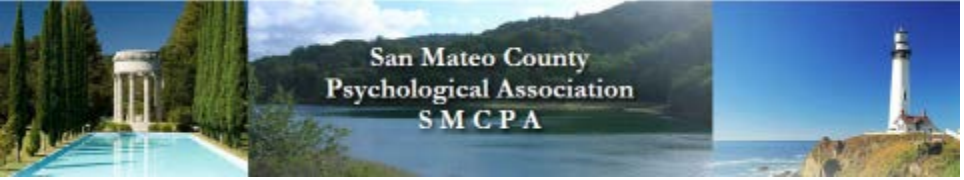
LEARNING OBJECTIVE 3

3. Analyze whether taking insurance payments, billing insurance, and/or being on managed care panels is right for your practice



Should I take MCO/Insurance payment?

- If you are licensed, you or your patients can bill insurance.
- Even if you are Out-Of-Network, most plans will pay something. Advise patients to check if they have OON coverage; some don't.
- Some companies will pay you directly. Some will pay your patient directly.

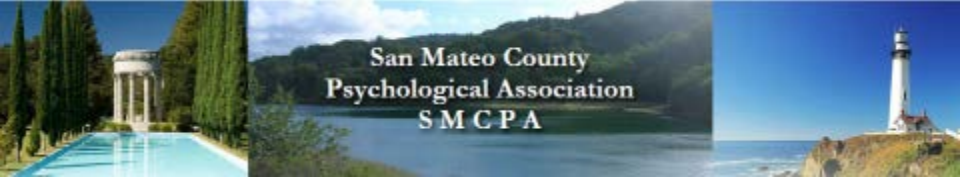


Should I get on any provider panels?

It Depends:

1. In what phase is your practice?

   How long have you been in practice at the current location?



Should I get on any provider panels?

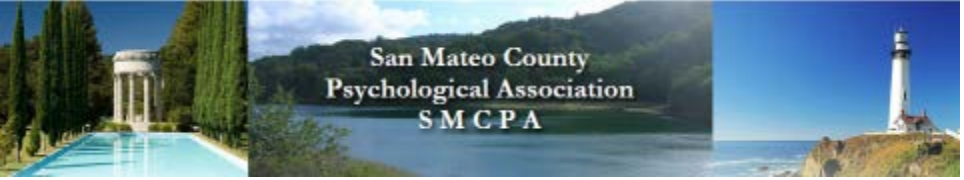
It Depends:

2. What are your current referral sources?

   Are your sources reliable?

   Are your sources diversified?

   Would the security of a steady inflow of referrals outweigh lower per session income?



Should I get on any provider panels?

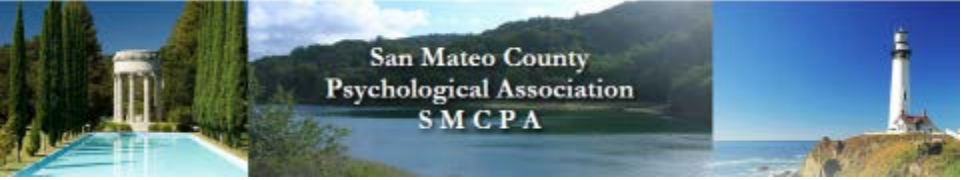
It Depends:

3. What are your financial goals for your practice?

   How many sessions/week do you want?

   Do you have a specialty that earns more revenue per session?

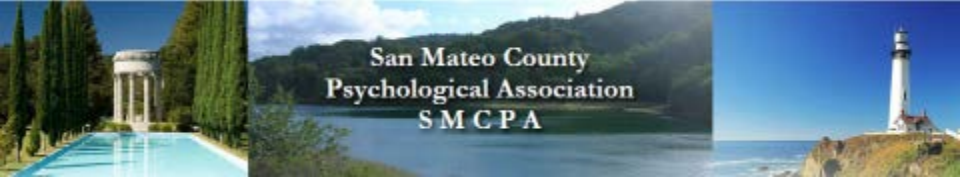
   Do you prefer to do marketing or see patients?



Should I get on any provider panels?

Considerations:

1. How do I know they will refer patients to me?
2. How much paperwork do they require?
   Patient progress and satisfaction reports, Case reviews
3. Can I negotiate better payment?
4. Do they allow tele-psych?
5. Call center responsiveness



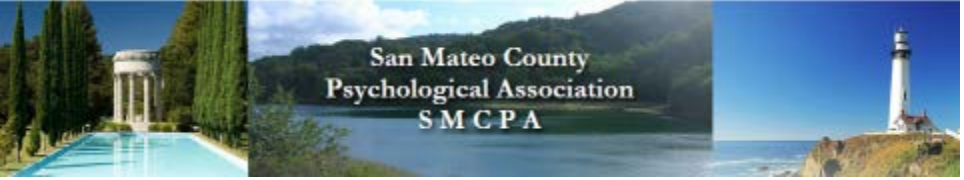
Which panels would be best for my practice?

Lower Pay, High Volume:
BHRS, Medi-Cal, UBH, Blue Shield, Magellan

Moderate Pay, Moderate Volume:
Beacon/ValueOptions (supporting Kaiser)

Higher Pay, No Referrals:
Medicare

There are many other panels: Anthem, Aetna, Cigna, HealthNet



How do I apply to get on a panel?

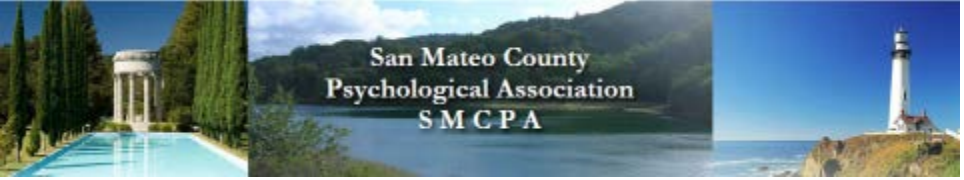
Each payer has a website where you can find information about applying to be on their provider panel.

BHRS: 650-573-2541 and ask

Medi-Cal: 800-541-5555 or
http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp#Forms

UBH (United Behavioral Health, Optum, United Healthcare):
https://www.providerexpress.com/content/ope-provexpr/us/en/our-network.html

Beacon/ValueOptions:
https://www.beaconhealthoptions.com/providers/how-to-become-a-provider/



How do I apply to get on panel?

Blue Shield, Blue Shield FEP: 800-258-3091

https://www.blueshieldca.com/provider/guidelines-resources/prospective-providers/join/home.sp

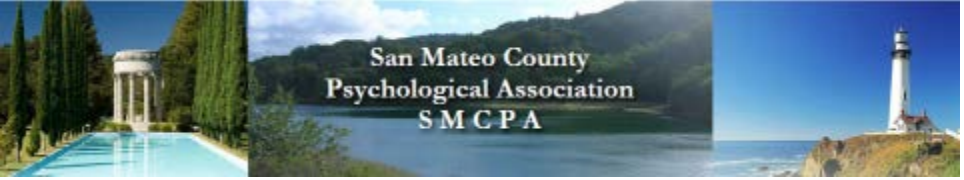
Magellan, Blue Shield MHSA:

https://www.magellanprovider.com/mpMap/do/providerGateway

Medicare: It is complicated; start by getting an NPI

http://drherz.us/for-professionals/medicare-resources-for-psychologists/how-to-enroll-as-a-medicare-psychologist/

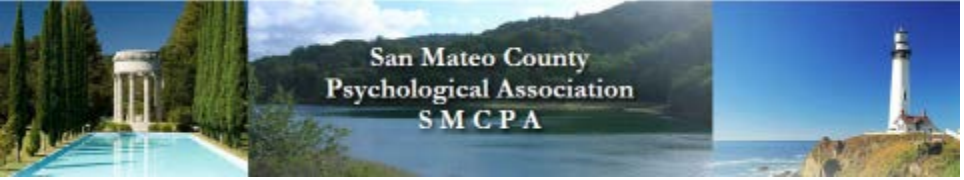
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html?redirect=/MedicareProviderSupEnroll/



OK, but really, how do I get on a panel?

They always say their network is full.

1. Do you have a specialty; for example:
   Multi-lingual, teenage drug abuse, DBT with cutters, post-discharge treatment, you are a racial minority?
2. Do you have a practice address in an town where they are accepting new providers?
3. Are you already seeing several of their members?

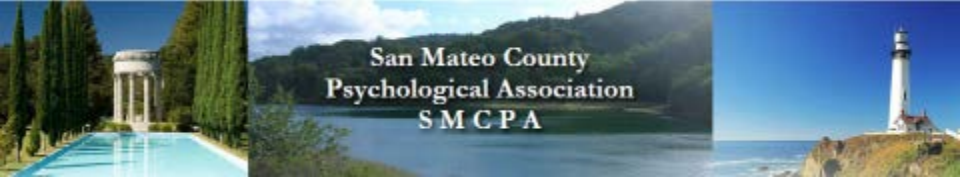


Once I'm on the panel, am I good to go?

Maybe! Remember, your contract is **per plan**.

Example: Blue Shield versus Blue Shield FEP versus Blue Shield MHSA (aka Magellan)

***Always make sure your services are covered by the patient's benefits*.** If in doubt, check the patient's Eligibility by calling or going to the payer's provider web portal.

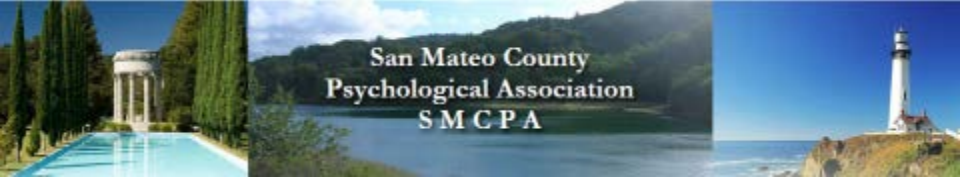


Practice Development Strategy

In the early phase of a practice, use managed care to fill your hours.

As your schedule fill and you develop a history providing *effective and efficient** care to the payers, ask to negotiate higher rates. Slowly drop the lowest paying ones who refuse.

*Good outcomes, appropriate duration and cost

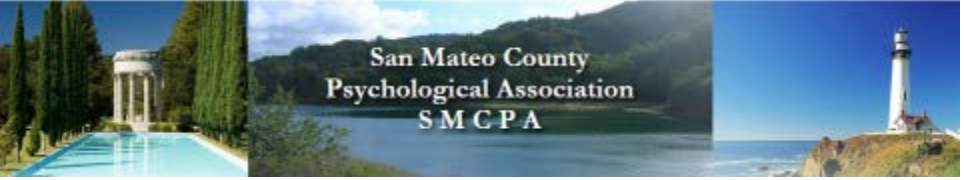


Practice Development Strategy

As your referral sources become stable and reliable, continue dropping the lowest paying panels.

Then decide if you wish to retain one or two *best** networks as a hedge against downturns. You can always tell the payer that your schedule is full so you can reserve schedule slots for higher paying patients.

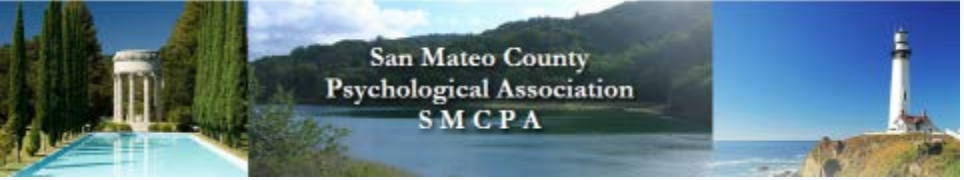
*Good pay, minimal demands, good relationship with case managers, call center, and provider relations



Practice Development Strategy

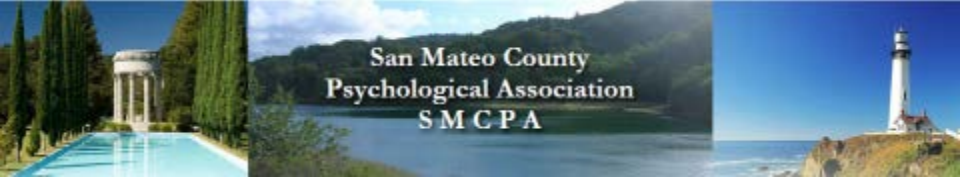
If patients are seeking your care and are members of a payer with which you are contracted, and you are sure they would pay your full fee out-of-pocket if you were NOT on their panel, consider terminating your network contract.

To preserve continuity of care, you might need to make special payment agreements with some patients.



LEARNING OBJECTIVE 4

4. Assess whether practice management billing software or a billing service is right for you

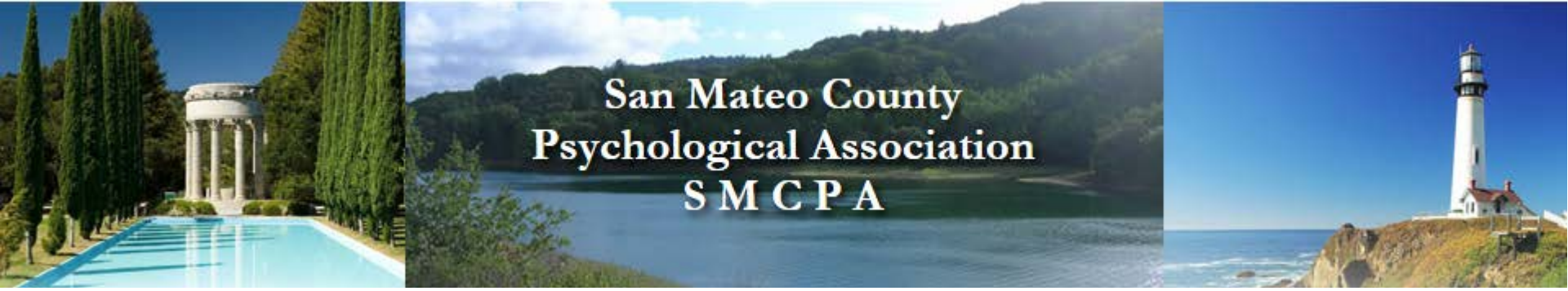


Can I Automate Any of This?

- Payer provider web portal: submit claims, check claim status, get ERA's, request reprocessing, and appeal denials
- Software packages with link to a Claims Clearinghouse, and automatic deposit to your account

  Examples: Office Ally, Therasoft, Empathic, Therapist Helper, PsychConsult, and many others

  We will review these and others at our Workshop on Saturday September 16
- Billing Service: Charge % of collections or per claim



Q & A

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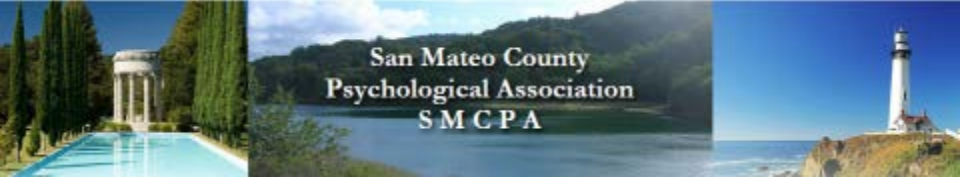
www.BayAreaHealthPsychology.com

www.CaseKeepers.com



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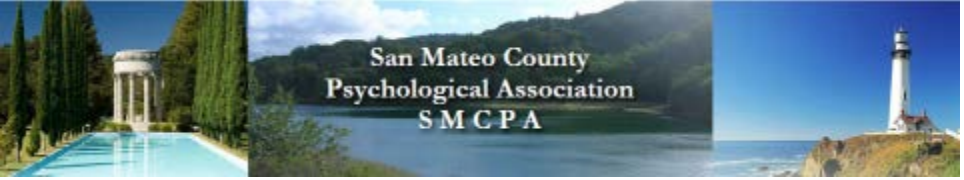
http://www.biblio.com/book/managing-managed-care-mental-health-practitioners/d/565335745

Managing Managed Care: A Handbook for Mental Health Professionals 2nd Edition, ISBN-13: 978-0880487726

Includes method for documenting and communicating the necessity, appropriateness, and course of treatment for managed care review. Using the Patient Impairment Profile method, practitioners can convey a rationale for treatment, efficiently track progress, and demonstrate favorable patient outcomes.

https://www.amazon.com/Managing-Managed-Care-Second-Professionals/dp/0880487720



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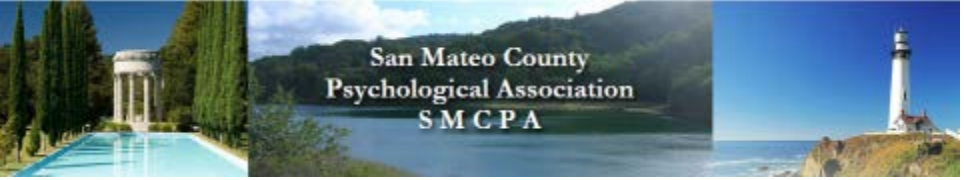
Casebook for Managing Managed Care, A Self-Study Guide for Treatment Planning, Documentation, and Communication, Jeffrey P. Bjorck, Ph.D., Janet Brown, R.N., C.P.H.Q., and Michael Goodman, M.D.

Helps mental healthcare practitioners clearly articulate and prove the value of what they provide patients within the managed care system, this foundational text uniquely fills a gap in the literature by providing a user-friendly, self-contained tutorial for the Patient Impairment Profile (PIP) documentation method. The PIP combines impairment terminology, the impairment profile, and the various treatment plan components to create a common language for describing behavior-based patient dysfunction and communicating the clinical rationale for treatment.

As a model for treatment plan development, the PIP system trains the practitioner (or treatment team) in the "must-have" skills needed for todays managed care environment. Here practitioners will find explicit instructions about how to:

- Communicate treatment needs convincingly
- Distinguish effectively between goals, objectives, and interventions
- Track progress over time
- Document treatment summaries efficiently

https://www.appi.org/Casebook_for_Managing_Managed_Care



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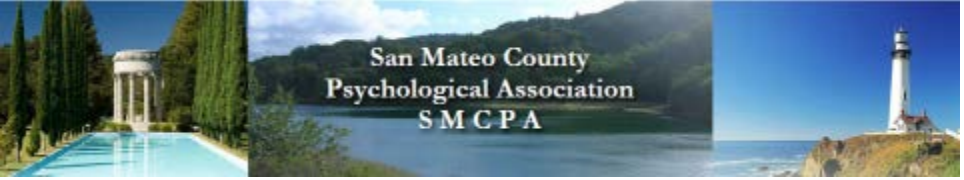
Managing Managed Care: Quality Improvement in Behavioral Health. Psychiatric Services, 49(11), p. 1504, Arnold Korotkin, Nov 1, 1998

This report from the Institute of Medicine provides managed behavioral health care consumers and providers with a guide "to the development, use, and evaluation of performance indicators, accreditation standards, and quality improvement mechanisms" that should foster the purchase and delivery of quality services and benefits in a cost-effective and efficient manner.

https://doi.org.10.1176/ps.49.11.1504



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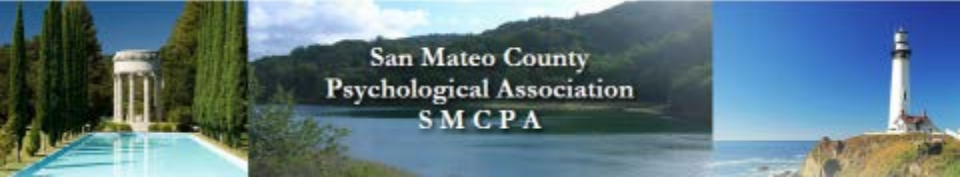

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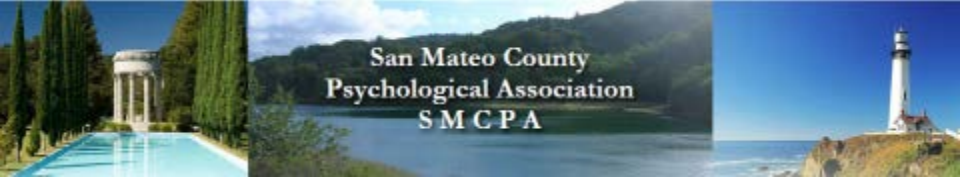

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