Make Every Session Count: Managing Under Managed Care

Finding Your Way through the Managed Care Maze

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BRIEF THERAPY HAS been around for many years, in one form or another. Why is it suddenly so popular? The answers are simple, and incredibly complex, *time* and *money*.

Everyone feels the press of time these days. We all want to deal with problems quickly and get on with our lives. Brief therapy can't solve all the problems we face but, as you've seen in this book, it can be a great help. This makes brief therapy a very attractive option.

"Brief" is also generally seen as "cost-effective." With health care costs escalating out of sight, procedures that provide effective treatment at low cost are in great demand. Private and government health insurance programs and health care organizations have looked for every possible way to cut costs, and "cost-effective" has become a mantra repeated by regulators, health professionals, and patients alike.

The system that evolved in response to these demands has come to be known as "managed care." For better or for worse, the "managers" are the outfits that pay the bills—your employer who chooses medical care policies, insurance companies, government agencies, health maintenance organizations.

With the advent of managed care, health care as many of us have known it is forever changed. The "good old days" of the sixties, seventies, eighties—when you could see any physician or health care provider and have your insurance pick up the tab—are long gone for most of us.

And you're not exempt from some of these changes if you use a public hospital or university counseling center, or even if you pay for your own health care. The new system has changed more than just the way the bills are paid. The pace of everything is faster now, and all benefits are subject to careful evaluation and review. Doctors don't have much time to "visit" with patients anymore. Health care, including psychotherapy, follows a briefer problem-solving model more than ever before.

In the mental health field, new brief care standards have become routine in independent and group private practice, community mental health centers, college and university counseling centers and health clinics, public and private hospital psychiatry departments…virtually anywhere mental health professionals practice.

For simplicity in this chapter, we'll discuss all brief therapy settings as "managed care," although university centers and other public agencies may not use that term. There will, of course, be differences among various agencies, but the process of intake, referral, planning, and evaluation—and the headaches of paperwork—are similar.

Keep in mind that the discussion in this chapter refers to programs of therapy that are covered as benefits under a health care plan. You can get virtually any therapy you want or need if you are able and willing to pay for it yourself.

What Mental Health Benefits Are Available under Managed Care?

Most managed care companies and agencies offer restricted mental health benefits. You can't just pick up a phone book and choose a doctor or counselor. And you can't get coverage for all conditions. Getting what you need under managed care is rarely as simple as the ads for your care plan would have you believe!

To ensure you have as much information as possible and can make educated choices as a proactive, responsible partner in obtaining your own care, read your benefits book *carefully* and *completely*, until you understand it. Ask questions. Don't be afraid to advocate for what you want; to ask questions about your benefits, services that seem to be missing, how to obtain *any* particular benefit. Most managed care organizations are willing to spend time with you on the phone to help you understand what services you are eligible for and how to access them.

Typical mental health conditions covered under managed care tend to be those that require an *immediate* intervention:

- *Emergency care*—for patients who may be dangerous to themselves or others
- *Acute care*—for short-term life crises
- *Marital or family conflict*—especially if abuse is involved
- *Brief solution-focused problem solving*
- *Assessment and referral for chronic mental illness*—screening for long-term therapy

How Can You Make Managed Care Work for You?

For you, as a consumer and client, the easiest, most useful way to get services is to educate yourself regarding

several basic aspects and limitations of the managed care model.

When you want or need to seek emotional support under your health care plan, remember that there is almost always a "protocol" to follow: a specific set of predictable steps and tasks you *must* follow in order to get services.

Often the mental health benefit (or "behavioral health" benefit as it is often called) requires a referral from your "primary care" physician. Thus, under the managed care plan, you can no longer simply see any licensed mental health professional, but must first request this service from your insurance plan, directly or through your primary care physician. The primary care provider is often (but not always) a general or family practitioner who has been assigned primary responsibility for your health care. In most plans, any referral to a needed specialist, including a psychotherapist, must come from your primary care provider. (In *some* plans, Kaiser, student counseling centers, a referral from a physician is not required.)

The thinking behind this "gatekeeper" approach is that by paying a general or family practitioner to handle most aspects of your care, the funding agency has a better handle on your actual medical needs.[1]

Help At Last!

When you get your referral it will often be directly to a Department of Psychiatry (if you belong to a "staff"-based model like Kaiser-Permanente), or to a specific group (if you belong to a "panel"-based model like Champus —a "panel" is a list of independent providers and practice groups who are approved by the plan). Most referrals are for a limited number of sessions, encouraging psychotherapists who work in managed care to adopt a brief therapy model.

Your therapist's first job, regardless of the model used as the basis of providing treatment, is to understand and assess as quickly as possible what is troubling you and how best to treat you. Based upon the initial assessment, the therapist will develop a "treatment plan" designed to assist you. In managed care, the treatment plan is based on resolving your current condition within the limits of your health benefits plan. After the number of therapy sessions called for in the treatment plan, additional sessions must be authorized through the managed care system's review process, and will be allowed *only* if need is shown. The assumption is that some difficulties can be addressed adequately in as few as one to three sessions. Managed care incorporates a system of checks and balances designed to ensure continuing access to care only if the company agrees with your therapist that such care is necessary and fits

within the scope of your benefit plan.

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Two basic ingredients typical of most managed care models are designed to insure that you are getting the best necessary treatment within the limitations of the plan: *utilization review* and *case management*. Both of these mechanisms require your therapist (aka "provider") to get permission or "preauthorization" from a representative of the health plan before providing certain diagnostic or therapeutic intervention. The intent is not to delay care, but to monitor the cost, necessity, and quality of your care. Unfortunately, this also means more paperwork and telephone time for your therapist outside of your sessions.

Privacy and confidentiality—traditional cornerstones of the therapeutic relationship—are a bit shaky in the new managed care environment. (There are also legal limits to confidentiality. See Appendix A for a typical therapist's confidentiality statement.) If you elect to have your health care plan pay for your brief (or other) psychotherapy, the plan's representative may become, in effect, a "third party" in the therapist's office. In other words, confidentiality in the traditional sense, your right to privacy, may be compromised if your insurance company is to pay. These days, insurance companies and other payers often require fairly detailed information about therapy clients and their treatment in order to determine whether or not to authorize additional sessions. This is in response to the need to monitor costs, yet it also is a practice many therapists *strongly* oppose. Please feel free to talk to your therapist about this issue so you can be assured regarding the degree of confidentiality.

Whether you're trying to get a first appointment authorized or your therapist has requested additional visits, you may have to be an active partner in the pursuit of the assistance you need by talking directly with your health plan's representative.

While the red tape can be frustrating, it can be empowering to accept responsibility as an active participant in your own care. Just as your brief treatment will be focused and quite specific, so will the steps required of you to obtain treatment on your behalf within a managed care benefit. Taking the time to understand these steps as a knowledgeable and educated consumer *before* you actually need help or assistance will maximize the possibility of a relatively straightforward, uncomplicated process at a time of need—when a minimum of stress may be crucial.

How Can You Tell If You're Getting Good Care?

There are some standards that may be applied to any health care situation to help you determine if you're getting quality care. Most managed care agencies use some or all of the following criteria to balance the "cost-effectiveness" equation:

- Informed consent of the patient, with ample information provided at the outset
- Assurance of confidentiality (see Appendix A)
- Careful assessment and treatment planning.
- Objective evaluation procedures (tests, surveys, peer review by other professionals)
- Research support for treatment procedures (literature references should be available if you ask)

Putting It All Together

Now let's take a look at a few examples of folks accessing their managed mental health benefits:

George *is a twenty-seven-year-old whose wife has just left him. He had never been married before, nor seen or even considered seeing a counselor. He comes from a fairly conservative background and thought only "crazy" people see shrinks, but has never been this upset before either. He is having a hard time at work, his mind wanders, he is having difficulty sleeping and always feels tired. He doesn't know whom to talk with or even if he wants to talk. He decides that if only he could get some rest things would be better so he decides to see his doctor. His physician examines him and refers him to a counselor; he feels even more upset, as he had just wanted something to help him sleep. As he leaves the office, the nurse asks him what kind of insurance he has. He gives her his insurance card and she hands him a referral slip (or "preauthorization") for three visits. His insurance works with a "preferred provider panel" so he can look in his "participating provider book" and contact any conveniently located counselor listed. She reminds him that it is important when calling to tell the counselor not only the doctor who referred him, but the kind of insurance he has. He thinks about it, has another difficult evening, reluctantly calls the next day, and gets an appointment for later in the week. By the second visit he vows he made the right decision. While he is still struggling, he has found talking helpful. The homework his therapist assigned has been useful and he feels better doing something to take charge of his life. Toward the end of the visit, both George and the therapist decide that it would be helpful if their work could continue so the therapist requests*

preauthorization for several additional visits, reminding him to work hard between sessions, as time is short and "every session counts."

***Alicia** is a nineteen-year-old sophomore at a state university. An average student, her attention has recently been focused on her boyfriend, Alan. She arrived at the university psychological clinic after a referral by her dorm counselor when she began talking about suicide. Alan left school, joined the Army, and told Alicia to "start dating other guys." She was devastated, and says her life is over. The sensitive receptionist at the clinic connected Alicia immediately with the "intake counselor," who did an initial assessment of her condition and the likelihood that she would carry through on her threat. The counselor spent nearly two hours with Alicia, then walked her to the campus physician's office for a physical evaluation and possible anti-depressant medication. Alicia signed a short "contract" with the counselor, promising that she would not make any attempts on her life at least until she visited the counselor again in two days. The counselor consulted with the director of the clinic and with the referral physician. They developed a preliminary treatment plan for Alicia, involving three more sessions, another visit with the physician, a follow-up with the dorm counselor, and a short battery of psychological tests. After this short-term plan, Alicia will be re-evaluated to determine her need for continuing therapy at the clinic or in an outside treatment center. (This state university's counseling policy allows only eight visits before referral to an outside agency.)*

***Chuck** is eleven years old and has always been a good kid but has been having a hard time recently. For the last several years he has had increasing difficulty staying still in class or paying attention. He has become more impulsive and impatient at home. His parents, with the teacher's support, take him to see his pediatrician at Kaiser. After hearing the history, the doctor refers them to the Department of Psychiatry for an evaluation. They see Dr. Smith, a child psychologist, who has Chuck's parents and teacher fill out a long questionnaire. Dr. Smith reviews the records and family history, interviews the family and Chuck, and administers several psychological tests. She then refers Chuck to a child psychiatrist for a medication consultation. The decision is made to see if Chuck would benefit from a trial on medication, and the family continues to talk with Dr. Smith, who assigns a number of "homework assignments" to the family in their weekly meetings. Six weeks later Chuck's parents and teacher report that he is doing much better. Dr. Smith refers Chuck to his pediatrician, rescheduling the family for a routine follow-up appointment in three months.*

Taking Charge of Your Own Care

Basically, that's it. If you remember that *every session counts* and work hard to make the most of every one, many difficulties can improve in a short time. Don't forget that every managed care plan will have its own unique way of doing things but, in general, to access your mental health benefits you will need to:

- See what kind of mental heath care your particular plan offers by reading the benefits book *entirely* and contacting your health care representative with any questions or concerns. This will verify your understanding as a consumer and patient. Find out if you need a physician referral to see a therapist.

- Make an appointment with your primary care physician and let him or her know you need emotional support and ask that rather than simply prescribing medication for you that he or she facilitate a referral to a mental health specialist.

- Set up an appointment with the department, group, or individual to which you have been referred.

- Work hard with your therapist, remembering that *every session counts*. Identify the problem(s) troubling you and work in collaboration with your therapist to determine the best course of action available to you. Follow through assertively!

- Remember both you and your therapist have responsibility for your care. Each of you needs to work actively at verifying compliance with the managed care plan guidelines if you want them to help pay for treatment.

Notes

1 Often these physicians are entitled to provide care to a group of employees at a set monthly amount per person (or per capita, hence the trade term, "capitated care"). The fee does not fluctuate based upon the number of patients who come into the office or need the service of specialists.