The future of reimbursement for mental health and substance abuse disorders (saturday October 18, 1997; Los Angeles)

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Economic changes in health require the mental health practitioner to become knowledge of the reimbursement aspects of clinical practice. This presentation will address such issues as procedural and diagnostic terminology, medical necessity, documentation, as well as current initiatives within the American Medical Association and the Health Care Financing Administration. Anticipated trends in reimbursement will also be discussed.

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The Future of Reimbursement for Mental Health Services

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Dr. Puente is a professor of psychology at the University of North Carolina at Wilmington (UNCW) and a practicing clinical neuropsychologist. His interest in reimbursement issues, the subject of this presentation, is an outgrowth of the need over the past 10 or 15 years to become well acquainted with this complicated area.

Back in the mid-1980s, as he was starting his neuropsychology practice in North Carolina, Dr. Puente was unable to get reimbursed by third-party insurers. During his tenure as president of the North Carolina Psychology Association, he had requested the support of the American Medical Association (AMA) in establishing a Current Procedure Terminology (CPT) code for neuropsychological services. He also communicated this idea to Blue Cross and Blue Shield of North Carolina. Ten years later, that CPT code has been put in place with the cooperation of the Health Care Financing Administration (HCFA). Soon after the code was instituted, more work was done with AMA and HCFA, and about 2 years ago the AMA established an advisory panel for the CPT system; Dr. Puente served as the panel representative for the American Psychological Association (APA). He also worked with HCFA—for the past 3 to 4 years with the medical director—to help establish a policy for psychological and mental health services as provided by neuropsychologists.

Dr. Puente established his practice in neuropsychology in Wilmington in part because UNCW was not enthusiastic about supporting clinical activity within the context of his university appointment. Eventually, he joined a multidisciplinary physician group, which encompasses all physician specialties—from surgery to dermatology, excluding pediatrics—and comprises about 50 to 60 physicians. There are no psychiatrists in the group, and the three Ph.D.s are neuropsychologists. This presentation describes Dr. Puente's participation in that multidisciplinary group. Dr. Puente is not a public policymaker nor a reimbursement

researcher. His presentation is one provider's experience in working with AMA, HCFA, and a group of physicians that works in the complex world of managed care and third-party reimbursement.

The reimbursement world is complicated. This presentation could have been subtitled "From Comfort to Chaos," "Speaking in Tongues," or "Why I Should Become an Attorney." The 5 to 10 percent of clinical or working hours that used to be spent on administrative activities is now up to about 20 to 25 percent, an increasingly large portion of the clinician's work. Another subtitle could be "No Matter What, You Are Screwed" because reimbursement is a scenario in which the clinician is always playing catchup; what was acceptable at the beginning of the year is not acceptable at the end of the year. But probably the best subtitle would be "There Is No Future for Mental Health Reimbursement."

The first part of the presentation addresses some of the driving forces that are leading down a path of constant change and revision; the second part focuses on ways to resolve the problem. For example, Dr. Puente's group holds two 2-day retreats per year that include the participation of one or more consultants. After these retreats, participants come away depressed. The question becomes how much a clinician's salary will go down. Is it going to be 10 percent, 20 percent, 30 percent, 40 percent? For a cardiovascular surgeon, it may be 40 or 50 percent; a primary care provider might fare better. Mental health services could be a serious loser in this entire process, for several reasons, but there are also some solutions. If clinicians are sharp, mobile, and lucky, they could come out better in the process.

Four precipitating factors are driving this change: industry, the public, the government, and finances. For industry, the bottom line is dollars. Byron Well, executive director of the practice section of APA, has said that General Motors spends more on health care coverage than on steel to make its vehicles. Such a discrepancy becomes a source of concern, one that may be spiraling out of control. The Washington Business Group, which monitors this kind of activity for Fortune 500 companies, has plotted not only the rising cost of health care but also the lack of abatement. Some programs, such as Workers' Compensation, have no identifiable ceiling. This causes concern because businesses are not established to cover their

workers. They exist primarily to produce profits. In this day and age, profit pressure is increasing on everyone.

Many clinicians, including psychologists, have gotten around this situation by cost-shifting. For example, those involved in third-party reimbursement for standard Blue Cross and Blue Shield programs may find themselves in, for example, Workers' Compensation. Some neuropsychologists have left third-party reimbursements totally and are performing forensic services only. They have circumvented the entire process, but indirectly the cost is still being experienced by these companies. Thus, health care cost is going up, profit pressure is increasing, and the two are obviously headed for a disconcerting clash.

The public, which is partly to blame for this situation, is another driving force. These days, most mental health patients know more about what they are getting into. They are familiar with their options, and if they do not know, they seem comfortable in asking questions. Patients not only have more knowledge of their options, but also have an apparent willingness for decreased responsibility.

Third-party reimbursement is a contract between the client and the insurance company, not between the insurance company and the provider, although it now seems as if the provider is the person who contracts with these companies, with the patient willing to take less of a responsibility for reimbursement. When someone goes to the grocery store to purchase a gallon of milk, there is no need to file a third-party reimbursement and request to be billed at the end of the month; the milk is paid for there and then. With respect to increased liability, anyone who does not believe that defensive health care is being practiced is foolish. Dr. Puente stated that he sometimes feels like the primary referral source for neurologists and neurosurgeons, who are concerned about litigious, cost-smart patients. Most of his patients are acute and sicker. Several years ago patients who consulted with psychologists in private practice settings seemed, in many respects, to be less impaired, less problematic. Dr. Puente's patients now wait longer before seeing him than they did earlier in his practice. Confidentiality also is an issue.

Insurance has been a problem for his patients, who often sign up for new programs thinking that they are getting a better deal. They do not realize that in the long run there are unexpected limitations that cause more serious problems than anticipated. Patients are also more diverse. For example, a practice in psychology in the late 1970s and early 1980s typically treated middle-class and upper middle-class white Anglo-Saxon people with relatively straight-forward problems; that is not the case anymore, especially for those who work with more seriously mentally impaired individuals.

Government is also a major player. It has shifted the burden from the Federal to the State level. The State is also shifting its costs to the county or to the city. Everyone seems to be passing the buck; in some large institutions, the buck is being passed within departments. Everyone is trying to pass on health care costs to another segment in the process.

Medicare and medicaid are becoming an increasingly large portion of clinical practice, especially for providers who work with seriously mentally impaired patients, including substance abusers. As medicare goes, so goes the entire health care system. Some have said that companies like Prudential are willing to carry medicare as a contract simply to know how inexpensively and how efficiently a policy should be within its own health care programs.

Workers' Compensation used to be a boom, but it is now a huge problem. California is an excellent example of that.

There has been a shift from straight third-party reimbursement to managed care in places like Connecticut where, in some counties, almost all plans are managed care. Dr. Puente estimated that there were between 25 and 30 plans in his practice alone. He expressed having a working knowledge of 5 of them, a rough concept of another 5 or 10, and no idea what the other plans involve.

Apparently, some companies are subcontracting. For example, Cigna has subcontracted its mental health services to specific carriers, which complicates the picture and results in shrinking reimbursements.

Dr. Puente's usual and customary fee for medicare is now roughly one-third of what he charges for his services.

One big problem is that, although most health care is covered at 80 percent, most mental health coverage is at 50 percent, which places a larger burden on the patient. Neuropsychological assessment typically takes about 10 hours, which is a significant amount of money; most people cannot afford this cost up front.

In terms of how much a clinician can charge—per year, over the lifetime of the patient—the ceilings are lower. For example, Blue Cross and Blue Shield of North Carolina used to allow 5 hours of testing per patient per year, which is very little; now, in some instances, the patient can be tested only a certain number of hours per lifetime.

There also is a problem with the number of visits. For patients who are seriously mentally impaired, many managed health care plans do not "bend" adequately enough, and the responsibility then falls on the provider. Because the provider has ethically accepted a patient on the basis of a signed contract, the liability is not on the managed care company but on the provider. When a clinician is halfway into the services, and there are no additional sessions, what does he or she do?

Finally, approval of services is a difficult area. For example, a clinician may get approval for four visits but is required to schedule a managed care review at a time set by the company. Although some companies are more accommodating than others, this is an unreasonable situation for a provider to be in.

For the first 10 years of Dr. Puente's private practice, he was concerned only with using the latest technology and knowledge base and providing the best service possible. Several years ago, his multidisciplinary group decided that was disastrous. Now it plans, strategizes, and develops timelines and measures. At its twice-yearly retreats, the group carefully reviews its original plan and how well it is working. Then plan undergoes changes.

Dr. Puente's group rarely refuses to sign a health maintenance organization (HMO) contract, even a bad one, because not signing may cause problems later. It is almost better to sign the contract and later try to negotiate than to be without a contract at all. Although Dr. Puente's group is aggressive about this, it has chosen not to pursue approximately 5 percent of the contracts proffered.

The group also tries to become involved in Employee Assistance Programs. About 25 percent of Dr. Puente's group's practice comes from nonindemnity and HMO contracts—contracts with consultants at a hospital, contracts with rehabilitation hospitals, and so forth. Diversification decreases the likelihood of "getting hit" if one particular source of income decides to cancel the group's services. This broad-based approach is primarily with managed care companies, although it is not the only form of coverage.

Dr. Puente's group is now pursuing the development of its own HMO. There are several risks, including an initial outlay of several million dollars, which could result in a loss of $50,000 to $100,000 per participant. Another kind of partnership also may be feasible. For example, the group is considering joining with a large company like Blue Cross and Blue Shield, which will probably provide some advantages; but in return, the company may request a 30- to 50-percent return on the dollar. Dr. Puente believes that most physicians would be enthusiastic about going out on a limb to compete with, for example, U.S. Healthcare. Starting an HMO may be a reasonable approach.

Psychologists and mental health providers do not realize that a good managed care company is probably good in part because of its information system. Information may be the missing ingredient that can reveal who makes up the market: How many people are out there? How much money do they have? What kind of diseases do they have? What kinds of services are they willing to consider? Also important are provider profiles: Who provides what service? How much? How fast? How much do they charge? How aggressive are they? How many patients do they lose? What kind of diagnoses are patients being lost to?

The only choice is for _____ to _____ themselves; no one is beyond scrutiny—this is peer review at its finest. Dr. Puente's group is starting to develop an understanding of what its members do.

Two clinicians are aggressive and conduct indepth evaluations; another does evaluations that take one-third the time. This implies that one clinician might do well under managed care; the other two might do well under contracts.

Practice guidelines must be developed. For example, if a patient comes in for depression, certain events should occur. In addition, information systems must be developed in part to feed HCFA. Mental health providers, psychologists in particular, tend to think that HCFA is out to get them, but HCFA simply may not understand what clinicians do. Providing information and education will be an important source of eventual revenue for such providers. APA has been working on these two areas for the past several years.

Patients are the key to increased revenues. First and foremost, patients must accept increased responsibility; the provider is not under contract with the managed care company as much as patients are; they must be involved. In addition, patients need to be educated; they need to know what they have signed. In Dr. Puente's group, a first-time patient is asked to come in about 15 minutes early before for first appointment and spend that time with the receptionist, who educates him or her about patient and provider responsibilities. Patients also need to be educated about the services they receive; it seems that the more severely ill patients are, the less likely they are to understand.

Providers also need to work under decreased liability. For a clinician to feel that he or she is being paid less and sued more is a bad combination that does not result in effective clinical services.

How do providers get paid for services? Providers seem to be moving targets, either within a plan or contract or within the patient population. Because of the constant shifting, providers cannot make long-term plans. Dr. Puente's group believes that it cannot adhere to any particular approach for more than one quarter of a year. Instead, it reevaluates, at least quarterly, to establish the playing field, which changes all the time.

The CPT is the method of coding insurance services. Most important, services recorded on a HCFA form should include the procedure used. Mental health services and psychiatry services, according to the CPT code book, are the stepchildren of health services, partly because of the 50-percent copay. In

neuropsychology, for example, using one code under mental health services (the psychological testing code) will result in a reimbursement rate of 50 percent; using the neuropsychological testing code will obtain a reimbursement of 80 percent. The ceilings are also much more liberal under neurology.

The same situation holds true for therapy. Reimbursement for code 90844, a psychotherapy code, generally is 50 percent; for 9770, a new code called cognitive rehabilitation, which can be used for schizophrenics, the reimbursement rate is usually 80 percent. The CPT determines the rate of reimbursement.

The flip side is the diagnosis, which establishes the amount of payment. This is a huge problem. Dr. Puente's group uses the World Health Organization's International Classification Diseases (ICD) coding system and tries to avoid *DSM* codes. A *DSM* psychiatric code results in a capitated experience called mental health services; using ICD codes allows diagnosis of neuropsychological services outside of the *DSM* mental health services category.

Providers who do not use electronic filing are in the dark ages. Claims must be submitted quickly and efficiently. A reasonable fee schedule does not charge exorbitant amounts for services. An unreasonable fee schedule will cause claims to be returned. It is a good idea to come up with the most reasonable fee schedule using the information systems suggested above. It is also important to find out what other providers are charging, especially in the same ZIP Code, with similar degrees, and so forth. Establishing an efficient charge document is important. In the old days, hospital consults involved writing everything down on a piece of paper and giving it to the billing clerk. Now there are charge slips, some of which can be optically read, which decreases the chance of human error.

Dr. Puente's group used to bill once a month; now it bills once a day, as soon as the patient leaves the office. Within several nanoseconds, the patient's insurance claim is filed. If possible, the billing is done *while* the patient is receiving services so any problem can be resolved quickly.

Dr. Puente's group also generates regular reports and analyses. The three neuropsychologists and two technicians in his office generate reports monthly; soon, the reports will be done weekly. A printout contains all the CPT codes, including the number of hours, the amount billed for those codes, the reimbursement amount per insurance company, and so forth. Good clinicians who are bad business persons are not acceptable anymore.

Another potentially complicated issue involving payments concerns ethics. Mental health has to leave mental health; as long as mental health services providers are within the mental health boundaries, they will be seen by third-party reimbursers as individuals who serve less than the best. This is also true for surgeons, dermatologists, and neurologists.

Dr. Puente's group uses a "cheat sheet," which contains all the information needed by the receptionist and each practitioner. On one side are the CPT codes with checkoffs for whether a code is accepted; whether preauthorization is required and how to do it; and the kinds of payments and copayments. For example, 90906 is the code for biofeedback, which medicare does not reimburse. To get reimbursed for biofeedback, the code must be 90844, for relaxation/biofeedback. Doing biofeedback alone and coding it as 90906 gets no results.

It often appears as if providers are playing a coding game, and Dr. Puente has communicated to HCFA and medicare that this should not be happening. The CPT system should be open so that all mental health providers can have a better understanding of it. Other factors should dictate the market, not HCFA.

Mental health services providers may be in for a rude awakening. Multidisciplinary is the way to go. Specifically, if primary care is not part of a clinical practice, a provider is in serious trouble. Dr. Puente's multidisciplinary group was composed almost exclusively of specialists; now, it is working toward a percentage of about 40 percent primary care and 60 percent specialties, although the reverse may be more desirable.

Soon nondoctorate people will be providing many services traditionally done by doctorate-level professionals. The large percentage of psychotherapy eventually may be done by nondoctorate individuals. An recent article in *Professional Psychology* predicts a shift: Psychiatrists will perform the roles of a case manager, psychologists will perform other duties, and so forth. Tasks that were never done by social workers will be done by social workers. The tasks never expected of a bachelor-level person, like biofeedback, will be done by a college graduate. This is the wave of the future, although it is not necessarily the best way.

There should be better marketing of services—an unpleasant task for some, but one that must be done. There also must be new services, services that are not typically offered. For example, Dr. Puente's group is starting to offer mammograms, a service previously unheard of for neuropsychologists. A radiologist with particular expertise in that area was hired. This is another example of offering new products.

Longer office hours are another aspect. Dr. Puente's office used to be open from 8 a.m. to 5 p.m., then 8 a.m. to 6 p.m.; now it is open one evening a week and Saturday mornings; soon it may be open all day Saturday, then perhaps 7 days a week.

Referral sources must be educated about what a particular provider does; they do not know.

There also must be increased access to professionals so that no patient will have to wait more than 10 minutes to get a reply from someone, whether it is through an answering service or through calling in during regular working hours. No patient should be denied emergency services; every patient, especially mental health patients, should be seen within 24 hours. A patient should get an appointment within 2 weeks.

Providers must be responsive and have increased geographical access. Dr. Puente's main clinic is in the middle of town and is starting to establish feeder systems, for example, by contracting with primary care providers in outlying counties and working in nontraditional locations. A group called Work Returns works in an industrial setting with chronic pain patients who are trying to reestablish themselves in the vocational workforce. Practitioners must go to the patients instead of patients coming to the provider.

Hospitalizations will continue to decrease, including those for mental health patients as well as those who are severely ill. More and more services will be performed on an outpatient basis.

All these are merely stopgap approaches; they are neither sufficient nor inclusive and are meant to help only for the short-term. There must be long-term solutions that address issues such as health care reform and insurance reform, revising the system not only for patients and providers but also for the people who provide the services on the other end of the spectrum. Education of the public should be a required and ongoing activity.

Research data are a precursor to establishing new practice strategies. In addition, there must be a mechanism to take care of the 25 to 50 million people without insurance. Until then, the people in greatest need of services are being ignored. Through careful thinking and planning, individual providers can become successful in this unusual, changing market.