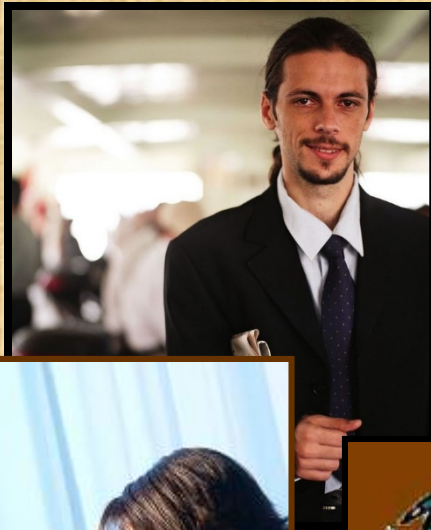


# More on Professional & Clinical Issues In Managed Care – a.k.a. ‘Understanding How HMOs Think, and How To Deal With It.’

This is the last lesson in this Course



a.k.a. – “Out of The Box!”

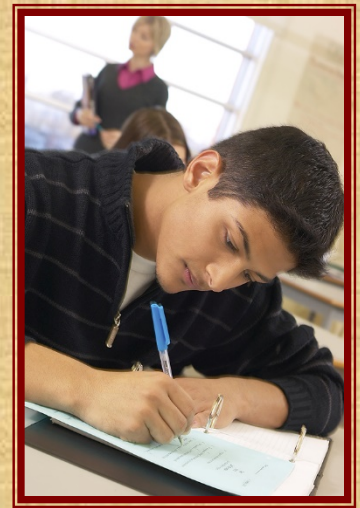
- Necessary Shifts in Program Design and Treatment Approach – *“The traditional way of doing treatment is no longer acceptable.”*
- Credentialing – *‘Are you qualified to deliver treatment?’*
- Documentation of Treatment – *‘But in your progress note, did you make it clear that ...?’*
- Care Management – *“Does he really need this Level of Care (LOC), or something else?”*


**In previous sections we mentioned the shifts in program design which come along with managed care. And yes, the HMOs are in fact re-designing the delivery system.**



**There ARE new OPTIONS for programming, which is good for providers. But – as we discussed in previous slides – along with the new options for treatment, there are new REQUIREMENTS for approval to deliver that treatment. And new requirements for DOCUMENTATION of the treatment. So let's talk a bit more about those issues.**

# Clinical Implications of Managed Care for Providers



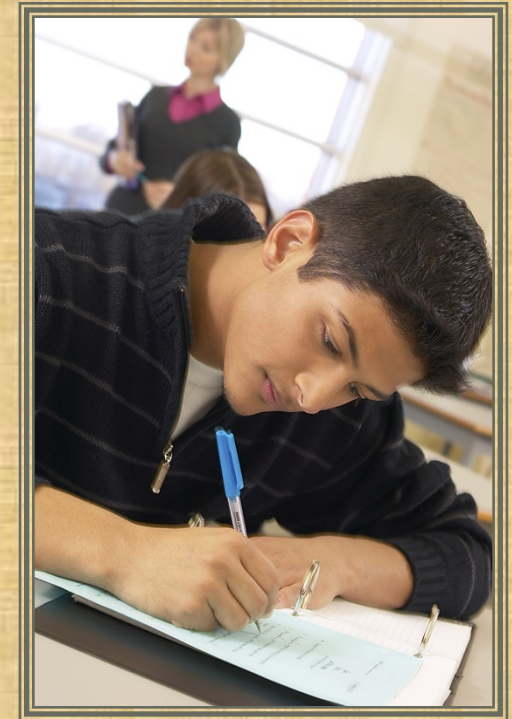
 Much of the 'art' of being successful under a managed care contract involves understanding what **YOUR** client's Care Manager means when he or she says 'There must be a **MEDICAL NECESSITY FOR TREATMENT** before I can authorize it.' Some are more rigid than others in defining 'Medical Necessity' – especially if funds for behavioral health are stretched thin. When this is the case, the provider must be particularly vigilant in how he or she presents the case for treatment.



# Communicating Your Client's Condition.





**If you have difficulty communicating the nature and severity of your client's condition to the Care Manager – in writing and verbally – you will have trouble obtaining authorization for services, especially under capitated managed care. You must be clear, clear, clear when you talk to the managed care company about what is needed. This improves your chances of getting what you want for your client.**



# And Then Documenting What You Did To Help Him, and WHY.



 **AND if you DO get authorization to deliver the services, will you have trouble DOCUMENTING WHY you did what you did? . . . or HOW you delivered the treatment? . . . or how the patient RESPONDED to the treatment? Maybe?**  **If you don't make these things clear to the HMO, you will be at risk of having to pay back money (called 'recoupment'). Why? The managed care company may RETROSPECTIVELY audit your clinical records (after they have paid you), to determine if the money they paid you to deliver the treatment was 'well spent' and that the treatment met the criteria for the service.**

## The Bottom Line Here . . .



- You must think about your client's treatment in the same way that the HMO's Care Manager is thinking when he or she reviews the case: **"WHY should the HMO spend money on this case – and for THIS treatment?"**
- You must put away soft-pedal language and euphemistic ways of talking about the client's problems.
- You must be willing to address **DYSFUNCTION** and **PROBLEMS** as well as strengths, because they do not pay for strengths – they pay for **STABILIZATION** of **DYSFUNCTION, PROBLEMS** and **SYMPTOMS!**





## Understanding How HMOs Think.

**If you do not understand how the 'MEDICAL NECESSITY' criteria are applied to the consumers in your care, getting approval from the HMO or other insurer to deliver treatment to your clients will be frustrating and confusing. The issue boils down to, essentially, 'Well, how sick IS he – and how MUCH of what KIND of treatment is really NECESSARY, and for HOW LONG'**

**When dealing with Behavioral Health (Mental Health, Substance Abuse, Chemical Dependency, or Dual Diagnoses), we are NOT talking about being 'physically sick' as in pneumonia or appendicitis. We are talking about mental and behavioral FUNCTIONALITY, and safety for self and others. These may seem like subjective concepts, to some.**

## And As We Said Before, Like It or Not, It IS 'Disease Management' – Not Social Service

- **Managed Care is 'Medical Model' – and we must adapt what we write in treatment records (charts), accordingly. The managed care approach is becoming increasingly 'medical' in orientation.**
- **'Medical' means TREATMENT – not simply social service or support. Health plans pay for TREATMENT which targets DYSFUNCTION**
- **When DELIVERING AND DOCUMENTING health plan services to individuals with behavioral health diagnoses, we must think 'clinical' and 'treatment' and 'remediation of DYSFUNCTION – which may be a major shift for many professionals.**



**We must crank up the 'treatment' perspective. We must make clinical-sounding statements (not just social service talk) in everything we write.**





## **‘Level of Care’ – It’s the Bottom Line, and Thus Worthy of a Bit of Review from Earlier Slides**

Many of the ‘old ways’ of providing treatment and of DOCUMENTING the treatment we provide have been discarded or radically modified. Why? A couple of reasons: Funds for health care in general are in very short supply in this country. In order to get a grip on this situation, it made sense that there should be more rigorous management of the LEVEL OF CARE (LOC) that we were providing – what KIND, how intensive (how OFTEN), and for HOW LONG?

And also, WHO IS SICK ENOUGH to get the more expensive treatments? This issue has had a major impact on who we treat – and at what LEVEL OF CARE (LOC)! This is particularly true for Chemical Dependency services and for treatment of persons with less-than-severe Mental Health disorders – like depressive episodes and anxiety disorders.<sup>9</sup>



## And Remember This, Too: 'Poorly Documented Level of Care' Is Deadly to Your Revenue!

**CRITICAL ISSUE:** Your client's treatment record **MUST** support the Level of Care (LOC – intensity of services) for which the HMO or other such managed care contractor is paying you! If they are paying for one of the more intensive Levels of Care such as Intensive Outpatient or detox, but your documentation looks like the client **DOES NOT MEET THE CRITERIA** for that Level of Care (i.e., he does not really need that level of intensity), you may have to **REPAY** some or all of the money that you have been paid for the period of time that the documentation did not appear to 'match the level'. That's called **RECOUPMENT** – not a good thing for the provider!

- **The main issue with insurance company auditors: “Does this chart justify what we are paying them to do the treatment – and is this Level of Care (LOC) really needed – and is it working?”**



- **Given this, we as providers MUST do ‘Internal Utilization Management’ within our practices and programs, to assess the clients’ LOC issues, on an ongoing basis.**

**More on this,  
next slide.**






*The need to do Internal Utilization Management (IUM).*

Remember . . . Just as the HMO, BHO, or MCO must carefully **MONITOR** the progress of the client through 'Care Management' (or 'Utilization Management'), the **PROVIDER** must *also* closely **MONITOR** 'how-often-how-much' treatment is needed and provided. Therefore you will need to develop an **INTERNAL UTILIZATION MANAGEMENT (IUM)** program, to monitor the appropriate Level of Care (LOC) and the **UTILIZATION** of services. Just like the HMO must do!


***Providers: Must do 'Internal Utilization Management' (IUM) to monitor the client's NEED for services AND how much service you have provided to him. Have you used up ('utilized') all of the approved units of service? If so, you will not be paid for additional services UNTIL you obtain a 're-auth' for more.***


***Note: Failure to perform this IUM task regularly can result in denied claims or recoupment of payments after you have received them!***



 **Health Insurers look at whether the individual is expected to BENEFIT from the treatment (based upon how he has RESPONDED and COOPERATED thus far, and his past HISTORY, and his DIAGNOSIS),**

**This 'internal' IUM activity meshes with the insurance carriers' approach to making LOC-based decisions.**

 **. . . and whether the treatment is considered to be 'NECESSARY' to recovery, based upon how IMPAIRED the individual is, and the 'PREVAILING STANDARDS of care' for his condition ,**

 **. . . and whether sufficient PROGRESS is being made to justify the continued expenditure of funds at this level of care. If insufficient progress is being made, then the treatment plan and perhaps the Level Of Care (LOC) will have to change.**





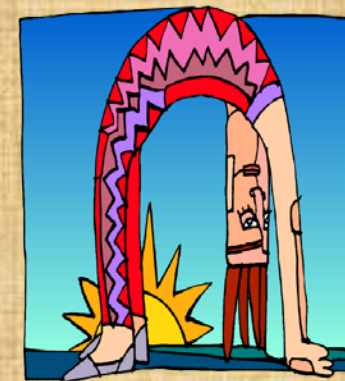
**Summary Statement:** For mental health consumers, Insurance Carriers DO NOT look simply at whether or not it would be 'helpful' or 'nice' for the individual to have a certain type of treatment, or whether the patient simply 'wants it'. And they DO NOT base decisions upon a plea that 'we have always done it this way.' Many of the 'old ways' have been discarded or radically modified, in this day of 'short funds' and more rigorous management of treatment. Who gets treatment and how much has changed – that's a major issue.

For the CD client, they DO NOT look simply at whether or not he or she is having an alcohol or drug related crisis, or whether or not he has experienced a recent relapse, in order to say 'OK' to a treatment request. And they DO NOT base decisions upon a plea that 'we have always done it this way.' In fact, if the client has had multiple relapses to use of alcohol or drugs despite treatment, they may begin to question whether additional treatment beyond detox and basic services is really justified. Again, who gets treatment and how much has changed.



**Does this mean that you can't say in the client's chart that you disagree with the Care Management Decision? NO. Document your beliefs clearly. It's part of your legal protection. But ALSO be flexible in providing and using alternative step-down programs for your clients.**





- **Review of an IMPORTANT NOTE: Is the managed care company telling you that you CANNOT provide the services which you believe the client needs? NO. A provider is *always* free to deliver any service to a patient according to the provider's own professional judgment or organizational philosophy. HOWEVER – if the managed care company does not feel that the services are **MEDICALLY NECESSARY** and **ESSENTIAL** for the stabilization of the patient (or if the health plan simply does not cover a certain service or limits how much can be provided), then you **WILL NOT BE PAID** by the managed care company to provide the service. You will have to do it for free ('pro bono'), or will have to use other funds to cover the cost.**

**This decision is becoming easier for treatment providers, in this day of shrinking health care funds. Patients are also becoming accustomed to the fact that there may be limits placed on what services are available, or the amount of services that can be provided. Sometimes there are other programs or funding opportunities available to pick up the slack – but not always.**



**SO . . . what about alternative treatments that are less expensive, which may work even better?  
Always consider those options!**



# Remember The 4 Core Concepts From Module 201?

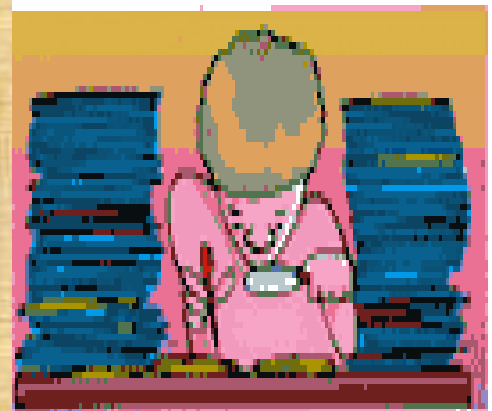
**Remember that Managed Care plans and even Commercial Insurance carriers approve or deny treatment based upon some CORE CONCEPTS related to LEVEL OF CARE. The list of these 4 concepts is on the next page, for review. If you remember nothing else about this course, retain these 4 Core Concepts which guide approval for treatment. EVERYTHING that we write in a client's treatment record (chart) needs to be guided by these concepts. What we write in the record SUPPORTS THE AUTHORIZATION that we obtained, and demonstrates that we did in fact PROVIDE THE TREATMENT which was authorized.**

- 1. *Medical Necessity – Needed to Improve, Maintain, or Prevent Deterioration?***
- 2. *Current Functionality – Diagnosis is Not Enough***
- 3. *Treatment Goals & Interventions – Do They Match Dx and Functionality and Service Descriptions?***
- 4. *Progress – Responding to Treatment, Likely to Benefit with More?***

**Q: Do these 4 HMO concepts ALWAYS shape what we write in a treatment record?**

**A: YES, if you want to be paid for what you do. When an HMO or other such managed care company has paid the provider for providing a 'billed service' to an enrollee, they ASSUME that we have adhered to ALL of these Core Concepts seen on previous pages.**

**But the only way that they can know for sure that we have been faithful to these concepts is to READ THE RECORDS. It's called an AUDIT. If the HMO finds our records to be lacking, they can take back all or a portion of what they have paid us. Certainly, this is to be avoided!**






# Why Are HMOs So 'Picky'?

**WHY** are the HMOs so 'picky'? Remember that in public sector healthcare programs such as Medicaid, funds are generally short all the way around – much more so than in commercial private insurance plans.



 The funds available to the managed care company are quite **LIMITED**, while the needs of the enrollees is **GREAT**. Obviously, the use of the limited funds by **YOU**, the provider, must be carefully **MONITORED**.



They are going to take a **CLOSE** look at what you did with their money.

**This means that the managed care company will be taking a VERY close look at whether providers have ACCURATELY reflected the seriousness of the consumer's condition when requesting services, and then, was treatment delivered EFFECTIVELY. And does the amount that you billed correspond with what is DOCUMENTED in the consumer's record? And is the LOC clearly reflected in all areas of the record? If not, there will be problems!**



## Alternatives to traditional treatment!

📁 Even if the provider is opposed to the Insurance Carrier's practice of 'stepping the consumer down' to lower levels of care, it is important that he be willing to work with the **ALTERNATIVE APPROACHES TO TREATMENT** which are promoted by many managed care companies and will likely be made available within the network.

📁 Over the past few years, programs have been re-designed with good results. Some of the best emphasize community based treatment alternatives which teach **SKILLS** to effectively deal with symptoms and to live and work successfully within the community. Even in 'commercial' managed care plans, long term 'talk therapies' have given way to a briefer, more **COGNITIVE AND BEHAVIORAL** approach to anxiety and depression.





## **And remember that alternative services may be even better for the client!**

**Managed care companies and flexible behavioral health providers have begun to emphasize INNOVATIVE SERVICES (a.k.a. 'non-traditional' or 'alternative' treatments) which are 'outside the box' – i.e., which depart from the traditional way that services have always been provided. And we have found that many of these treatments work BETTER and perhaps FASTER than the traditional approaches.**



# **New opportunities are abounding!**

**If such DIVERSIONARY and STEP-DOWN services are not already available among current providers within the community, the HMO will likely approach the current providers at some point to START delivering these services. And IF they are not willing to provide specialized services, the HMO will SEARCH for NEW players (from inside or outside the delivery system) to provide the services. This has major implications for providers who want to participate in a managed care plan.**



**But how do these specialized services get worked into the Provider's contract with the HMO or commercial insurance plan?**

Many HMOs and commercial insurance carriers will NOT add specialized services to a Provider's Agreement until some weeks or even months into the contract, so that they can see what is actually needed – and so that they can assess the functioning of the provider. **Note:** BUT don't hesitate to ask about adding some special contract options and services – even before the HMO has indicated an interest!



# Flexibility In Programming – It Can Be Painful to Some.

**Under Managed Care**, program design often takes new twists that are unfamiliar to some professionals and Boards of Directors. Like what? Programs such as Intensive In-Home Services, out-of-office service delivery . . . true 24 hour availability and the need to extend telephonic response to 'around the clock' . Some Boards of Directors AND PROVIDERS are fearful of the inherent legal liability of out-of-office services. And we also see new requirements that can be irksome . . . such as the need to pass through some sort of external Utilization Review (UR – or Care Management) to obtain permission to treat . . . having to play 'Mother May I?' with the MCO. These are major issues to the uninitiated.





**One example of an alternative service that we may be able to deliver under managed care – previously not available to some Medicaid clients, although most of you are familiar with these services: *Community based or home based treatment*. Here, services are focused upon training the child or adult in effective community living skills and in the ‘recovery skills’ that he needs on a day to day basis. FOR MH CLIENTS, the training occurs out there in the community where the consumer lives and works, instead of in a Day Treatment program. This approach has proved to be far superior to facility-based services, for adults and children with a major mental illness. FOR CHEMICALLY DEPENDENT CONSUMERS, Intensive Outpatient Programs after work and evenings – instead of a routine ‘28 Day’ residential admission – have proved very helpful in preventing recidivism, especially when used early in the addiction cycle.**

# Credentialing!

- **CREDENTIALING** is required by managed care – and it can be truly threatening (even daunting) for providers . . . especially not-for-profit programs which oftentimes have taken the paraprofessional path, instead of hiring heavily on the licensed clinician side. Credentialing is unavoidable, in one form or another. This relates to training, experience, and licensure. Managed Care tends to be focused upon licensure.



*Your papers, please?*



# Other Issues for Professionals . . .



- HMOs require more licensed staff – programs and group practices should consider *contracted clinicians* (instead of full time employees) to fill in the gaps. Managed Care plans may also require a Medicaid Provider number, irksome to some Boards and individuals.

# Other Issues for Professionals . . .

- **Lobby (educate) the MCOs about flexibility in professional credentialing requirements. Press for approval of unlicensed Masters clinicians under licensed supervision, LCDCs, BA's and paraprofessionals to perform non-traditional MH and SA outpatient services such as 'wrap-around', CD education and counseling, intensive case management, and 'psychosocial rehab' services.**



# Other Issues for Professionals . . .

- **Credentialing 'accommodations' such as these are coming on strong in public sector managed care programs, despite occasional negative responses when HMOs and BHOs are first approached.**  
**"Unlicensed? Oh, NO, we can't – we are NCQA Accredited!" Well, yes they can, for certain services – particularly the 'innovative' non-traditional services. And they typically will approve these requests, with proper groundwork. And besides, these unlicensed positions are cost-effective for the HMOs!**





# Our Reputations and Financial Wellbeing Are On The Line – Where is Quality Assurance in This Mix?

**Bottom line, we are a service industry with HIGH VISIBILITY, GREAT VULNERABILITY. Treating sick people is a risk in itself. Managed Care, being the controversial movement that it is, makes recognition of 'risk' even more critical. We, our practice partners, our staff must understand this. So, too, our Boards of Directors, our owners, and our network partners. Develop a healthy fear of the newspaper reporter at your doorstep. Enter into a 'QUALITY MANAGEMENT' (QM) and 'RISK MANAGEMENT' mode of thinking. Course 2A deals with QM Programs For Behavioral Health – how to set them up, what to monitor and track.**

# It's a new day in clinical care. Rise to the occasion.



# Want to get details of how to audit your own records as the HMO will audit them?

**Lessons 2 and 3 of course 2B provide those details. You may wish to access that course, with the goal of knowing exactly HOW the HMO looks at records to determine compliance with Level of Care criteria and other such factors. Understanding these issues well in advance of an on-site or 'desk' audit by the HMO is important in order to protect your practice or program from recoupment of claims payments that you have already received from the HMO.**



**AUDITABLE RECORDS.  
'What Can Go Wrong In  
That Chart!'**

**The key to success. See  
Course 2B.**



# Congratulations!

**You have completed the 2<sup>nd</sup> lesson in Module 301. This is the last lesson in this Module, and the last lesson in Course 5A!**

**You must pass both Quiz 1 and Quiz 2 for Module 301, and must complete our short *Feedback* form for Module 301, to receive your CE Certificate. You can immediately download your certificate for this module – either now or later as you choose.**

**To reach the links for the quizzes and the feedback form, just close this web page and you will be returned to you're My Home Page, or return to [My Home Page](#) later.**

**Remember that you must pass all quizzes for the three (3) Modules in this Course 5A (Modules 101, 201, and 301), in order to receive three separate certificates totaling the number of credits stated in the catalog.**

**If you are choosing to 'save' the CE Credits that are available for any of the Modules in this course until a later time, you have one full year to study the lessons and take those quizzes. Thanks for your business, and come back to see us again at *CEU By Net!***

