

## Managing Change Within The Substance Abuse Culture - Lesson 2, Course 3B

# Programmatic and Counselor-Level Changes

**A bit of review . . . these are the main issues that impact CD providers under Managed Care**

- **Necessary Shifts in Program Design and Treatment Approach – *‘But we have strong traditions in the CD field, about what works and what doesn’t. Now you’re telling us to do WHAT?’***



- **HMO Credentialing – *‘Are you qualified?’ ‘Well, certainly we are. Why not? We always HAVE been!’***
- **Documentation of Treatment – *‘But in your progress note, did you make it clear that ....?’***
- **HMO Care Management – *‘How sick is he, and will he actually benefit from additional treatment, given his relapse history?’***

***We will explore these issues in this Lesson 2 and in Lesson 3.***

## **In plain language, what is really the issue here, with each of these statements?**

- 1. Necessary Shifts in Program Design and Treatment Approach**  
– *‘But we have strong traditions in the CD field, about what works and what doesn’t.’*

**The issue here, is that the CD treatment community is being required by Managed Care to abandon or to seriously modify many of its most cherished and historical treatment practices and options.**

- 2. HMO Credentialing – ‘Are you qualified?’**

**The issue here is that Managed Care wants more licensed providers than CD treatment providers typically have on hand.**

- 3. Documentation of Treatment – ‘But in your progress note, did you make it clear that ....?’**

**The issue here is that all providers (both Mental Health and CD Treatment providers) are being required to document in a way that is foreign to many of us – and noxious to many of us. More on this later.**

**4. HMO Care Management – *‘How sick is he, and will he actually benefit from additional treatment, given his relapse history ?’***

**The issue here is that with the limited funding available, Managed Care Companies cannot afford to ‘pour money down the drain’ in support of clients who are not going to benefit from the treatment no matter what is done.**

**Unfortunately for CD treatment, this basic need to ‘avoid needless waste of funds’ butts up against the plain fact that chemically dependent clients DO RELAPSE, REPEATEDLY as part of the recovery process. Therefore, they may well need more sustained effort to bring about recovery and stabilization than a severely mentally ill client, from the perspective that for the CD client, repeated relapse (perhaps over and over) is just part of the recovery process. Some companies will not support that approach due to short funds.**

## A Few Professional Implications of Managed Care for Providers



Part of being successful as a provider under managed care involves understanding what YOUR managed care company means by '... the patient has a **NEED FOR MEDICALLY NECESSARY TREATMENT**'.

Some are more rigid than others about how they define this need for treatment – particularly for CD clients – especially if funds for behavioral health are stretched thin. In states where CD money is lumped in with mental health money, this is a particular problem.





## Understanding How Managed Care Companies Think.

If you do not understand how the 'MEDICAL NECESSITY' criteria are applied to the clients in your care, getting approval from the Care Manager to deliver care to your clients will be frustrating and confusing. The issue boils down to, essentially, ' . . . Well, how sick IS he, anyway – and how much of what kind of treatment is really NECESSARY?'

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. This is a more 'subjective' issue.

## More on how they make Care Management decisions!



The issue of whether the client is expected to benefit from additional treatment is a thorny one for CD!

They 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**).

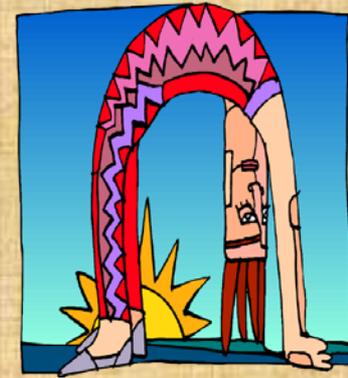
Also, whether the treatment is considered to be **'NECESSARY'** to recovery, based upon how **IMPAIRED** the individual is, and the **'PREVAILING STANDARDS** of care' for his condition .

And particularly challenging for CD – 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 the level of care will have to change!



**Remember that the Health Plan Contractors make their 'Care Management' decisions (a.k.a. 'Utilization Review') based upon whether or not they believe that treatment is 'MEDICALLY NECESSARY' for stabilization and improvement, and whether the treatment is believed to be ESSENTIAL for persons with the patient's DIAGNOSIS. Also, is the treatment you are providing having a POSITIVE IMPACT upon his or her condition?**

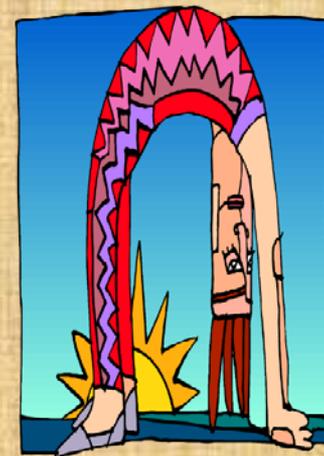
**For the CD client, Care Managers DO NOT look simply at whether the client is having an alcohol or drug related 'crisis', or whether or not he or she has experienced a recent relapse, in order to say 'OK' to a treatment request. And they DO NOT base decisions upon a plea that 'we have always done it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



**IMPORTANT SIDE 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.

**ANOTHER SIDE NOTE ON PROVIDER DECISIONS:** This is perhaps the most difficult decision that a provider must make when working within a managed care plan – i.e., do you provide a service for FREE, after the HMO says 'STOP'? Or do you terminate services because there are no funds to cover the cost?

This decision is becoming easier for treatment providers, in this day of shrinking health care funds. Clients 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, and sometimes the Health Plan approves good alternatives (IF they are available in the system) – but not always.



## Communicating Your Client's Condition.



**If you have difficulty *communicating* the nature and severity of your client's condition – 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.**



**The decision of the Health Plan – in response to your request to deliver treatment to your client – may well depend upon how you document the need for the treatment and how you carry out the treatment approach.**

## More on Documenting Your Client's Condition And What You Did To Help Him.



- 📁 **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 client 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 requirements for a 'Medical Necessity' approach to documenting the NEED FOR and the RESPONSE TO treatment may be a turn-off to private practitioners and program staff because it has to be so SPECIFIC. Many of us were trained to 'say as little as possible' in the client's chart, avoiding judgment-type statements, or things for which you might be cross examined in court.**

**Insurance companies (Health Plans) ALSO place a great deal of emphasis on whether or not the client will BENEFIT FROM additional treatment. For CD, this may be especially difficult; your documentation needs to communicate clearly why and how he will benefit from additional CD treatment, despite repeated relapse.**

**Philosophical conflicts with Care Managers about what AOD clients NEED in order to recover, have left some clients out in the cold, and their counselors hot under the collar. AOD clients demonstrate more than the usual amount of REGRESSION and RESISTANCE during their normal step-wise recovery process. Also challenging is the LOSS of traditional treatment methods like 28 Day Programs and Day Hospital - once believed to be 'essential' step-downs from detox. Yes, it's a challenge to get to a comfort level with such radical shifts. But some providers have done it! And although their outcomes aren't perfect, they are showing improvement in surprising ways.**

**Even time honored credentials to deliver SA-CD-AOD services have come under fire. Does it really take a Master's Degree to assess and treat a person with Alcohol and Drug issues? Some Health Care Plans believe that it does.**



**And although most CD philosophy AGREES that this is a DISEASE PROCESS, *writing about it* in this way is an entirely different matter. Many CD Counselors will need to be (re)trained to WRITE in a way that is 'clinical' and 'diagnostic', and oriented toward 'disease management'.**



**This is especially true for those CD Counselors whose philosophy comes from a highly didactic, teaching and educational model (rather than from a clinical model).**



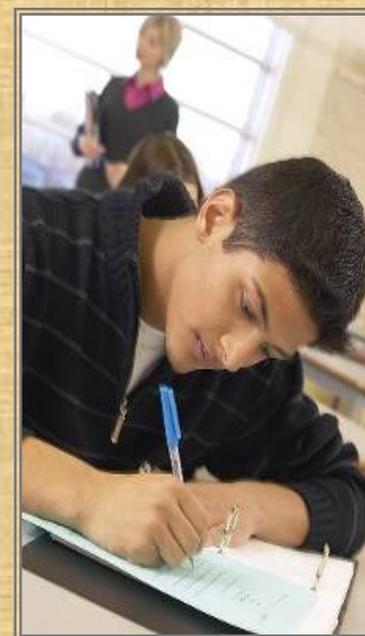
- **All of this may be irksome to some, regardless of whether they provide MH or CD treatment. It may even be impossible for others. If philosophical biases prohibit adaptation to managed care, some individuals may choose to not participate. Or may need to leave this particular field of play.**

## **The Core Concepts Behind Level of Care and Approval of Treatment**

**Managed Care plans approve or deny treatment based upon some CORE CONCEPTS related to LEVEL OF CARE (LOC) – and we are going to look at the four Core Concepts here.**

**EVERYTHING that we write in a client's treatment record (chart) needs to be guided by these concepts. Why? Because what we write in the record SUPPORTS THE AUTHORIZATION that we obtained, and demonstrates that we did in fact DO THE TREATMENT which was authorized.**

**One purpose of this course is for providers to understand that they CAN comply with these requirements within ETHICAL BOUNDARIES.**



## **The Four Core Concepts of Care Management – Yes, They Also Shape How We Document Treatment**



**The four core concepts that follow are dear to the heart of all Health Plans (whether they are publicly funded or commercial insurance companies) .... and these concepts determine whether they approve a treatment request or not. Obviously, these concepts should shape our approach to documentation within the client's treatment record (chart).**

**If we adhere to these concepts when we write in a client's record, we will ensure that we and the Health Plan are 'on the same page'. This is crucial, when the Health Plan's auditors come to pay us (AND our treatment records) a visit!**

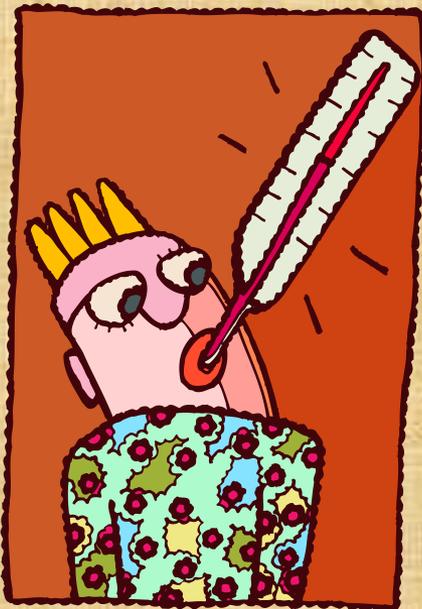
# 1. Medical Necessity

## THE CORE CONCEPTS Of Care Management

**1. It must be CLEAR that the treatment (the Level of Care or LOC) which is approved is MEDICALLY NECESSARY. Medical necessity is defined differently in every state. But these are some of the criteria that are quite common, in determining MEDICAL NECESSITY. The proposed treatments . . .**

- are REASONABLE AND NECESSARY in order to diagnosis or treat a specific mental health or chemical dependency disorder;**
- are needed to IMPROVE OR TO MAINTAIN or to prevent deterioration of functioning resulting from the disorder;**
- are in accord with PROFESSIONALLY ACCEPTED clinical guidelines and standards of practice for behavioral health care; and**

- are the most appropriate level or supply of service which can **SAFELY** be provided; and
- are furnished in the most appropriate and **LEAST RESTRICTIVE** setting in which services can be safely provided; and
- could not be omitted without **ADVERSELY AFFECTING** the Member's mental and/or physical health or the quality of care rendered, **AND**
- there is a **REASONABLE EXPECTATION** that the treatment will result in **PROGRESS**.



## **2. Functionality – It's Primary**

- **The diagnosis is important – BUT diagnosis alone will not justify a particular treatment. WHY? It is the patient's FUNCTIONALITY that is the most important, when deciding if a particular treatment is needed, and for how long. For example, an individual may have a diagnosis of Bipolar Disorder (and may have been hospitalized many times in the past) . . . but is now stabilized on medication, is back to work, is relating well to family and friends and co-workers, and is otherwise no longer a danger to himself or others. Does this individual continue to need intensive services? NO.**
- **On the other hand, e.g., if an individual is struggling with maintaining a job, is having acute symptoms of a disorder, is perhaps at risk of inpatient admission, and/or is having major difficulty with everyday functionality, then intensive treatment may well be considered MEDICALLY NECESSARY.**

### **3. Treatment Goals and Interventions – Must Match the Functional Deficits & the Diagnosis**

**When treatment is authorized, it is not a 'free pass' to do whatever the provider wants to do. The managed care company is authorizing a SPECIFIC SERVICE. And that is the only service for which we can submit a CLAIM FOR PAYMENT.**

**As to the DETAILS of how we provide the service, everything we do must address the major FUNCTIONAL ISSUES that we identified in the assessment, and for which we obtained the authorization to provide treatment.**

**And we CANNOT IGNORE A DIAGNOSIS! For example, if a consumer is depressed AND is also using or abusing DRUGS or alcohol, we MUST ADDRESS the substance abuse or dependency in the treatment plan and in the services we provide.**

**Managed Care cannot pour limited resources down the drain! Therefore, the Care Manager looks for PROGRESS being made, when we approach them to authorize more care. If a consumer is NOT RESPONDING to an approved service – i.e., if he is NOT MAKING PROGRESS, then we must . . .**

**. . . take a close DOCUMENTED look at what needs to be changed, AND THEN**

**4. Progress –  
It's Essential If  
We Are to  
Continue  
Treatment**

- **make significant CHANGES IN THE ITP – what we are doing with the consumer, and perhaps even**
- **REQUEST CHANGES IN THE AUTHORIZED SERVICE.**

**NOTE: If the individual FAILS TO BENEFIT from the treatment that is available to him, and has not benefited from revised plans of care, then the Health Plan may ultimately make a decision to move to a 'maintenance' regimen that seeks to keep the individual basically stable and out of danger. Goals to move the individual forward with significant progress may be abandoned, if it is clear that he has reached a 'plateau'. A PLATEAU means that it is *unlikely* that he is going to make additional progress regardless of what interventions are applied.**

## Why Are Health Insurance Plans 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. But even in commercial plans, money is becoming tighter all the time, as the cost of health care rises and the economy struggles.**



**📁 The funds available to the Health Plan are quite LIMITED, while the needs of the enrollees are GREAT. Obviously, the use of the limited funds by YOU, the provider, must be carefully MONITORED.**

Therefore ..... 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 client's condition when requesting services, and then, was treatment delivered EFFECTIVELY. And does the amount that you billed them correspond with what is DOCUMENTED in the client's record? If not, there will be problems!**



Program shifts? Yes! Program design must come 'out of the box' to be successful in managed care!

**What new 'out-of-the-box' programmatic shifts are worth considering, in order to be successful in managed care? This depends in part upon . . .**

- **the provider's own professional biases and beliefs**
- **the 'culture' of the provider's agency or practice (e.g., flexibility vs. rigidity, play-it-safe vs. trying a new direction).**



**Are you willing to examine your current beliefs about CD treatment, and about documentation in client records? Open to new ideas that managed care brings to the front?**

**It Requires Flexibility! You may have to set your historical beliefs about how to deliver treatment on the back burner.**



**A change-up of your historical approach to programming and practice may be CRUCIAL, if you are to compete and grow in this new healthcare environment. There is no room for 'but we have always done it this way!' In most states, Managed Care is NOT funded sufficiently to support 28-day programs. However, it IS typically funded to support alternatives such as very-short-stay residential followed by Intensive Outpatient Programs (IOP).**

## **Some alternatives may even be better for the client!**

**For both CD and MH treatment, 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.**



**Later on in this Course, in Lesson 3, we address some specific contractual alternatives for CD treatment providers to try under a managed care model – which maximize the provider's flexibility and the ability to maintain more control than we might ordinarily have.**

**As for basic program design . . .** For chemically dependent clients, managed care emphasizes Intensive Outpatient Programs (IOP) after work and evenings – instead of a routine ‘28 Day’ residential admission – and these programs have proved very helpful in preventing or reducing recidivism, especially when used early in the addiction cycle. Typically, the individual attends 4-5 times per week, and after a few weeks, is reduced to twice per week.

And if the health care plan is sufficiently funded, it may be possible to develop a contract for a ‘CASE RATE’ approach to treating extremely recidivistic clients, including chemically dependent adolescents. More on that in Lesson 3.

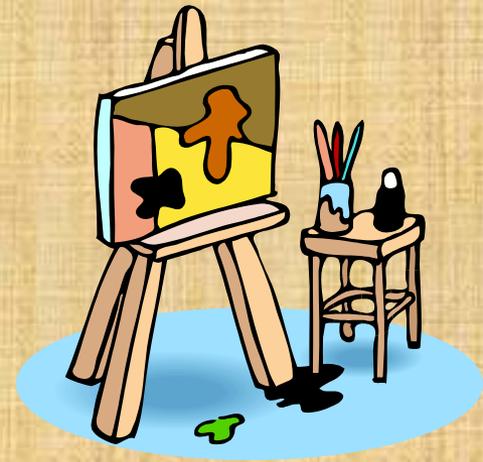
Adolescents with serious CD issues respond extremely well to Intensive Home Based services, as an alternative to long term residential treatment, whether the Provider’s reimbursement is based upon a Case Rate or Fee-For-Service.



## Re-Design . . .

**Programs which are newly expanding oftentimes cannot afford to hire full time clinicians. And, the not-for-profit agencies are oftentimes short on the licensed clinicians which are an unavoidable part the managed care scene. *Licensed contractors to the rescue!* As a contracted clinician for a small or new agency, you can have flexibility to work within your own schedule, but know that there will be a need to comply with many expectations for documentation and timeliness.**

## Re-Design . . .



**Licensed private practitioners who are 'managed care friendly' are finding multiple opportunities to contract their services to not-for-profit and for-profit organizations, on a part time basis. They make an effort to become a positive piece of the puzzle. This approach can fill in the gaps in a private practice schedule, and will bring in new revenue.**



## Re-Design . . .

- **Full time employment is NOT the only way for agencies to go – try JOB SHARING, and use (or be) one of those part time contractors for special functions and to fill in the gaps.**
- **Programs and practices: Be creative! Stagger operating hours to lure quality staff and contractors with a need for working hours outside of 9-to-5. Fits nicely with Home- and Community-Based programs. Most managed care companies require that we avoid a 9-5 operation anyway.**
- **Managers: Consider expanding vacation time for non-shift staff – generally has no direct costs, and pays off mightily!**



## Re-Design . . .

**And don't buy the old mantra that says that behavioral health providers should be limited to 18-20 hours of face-to-face (billable) intervention, weekly. This is perhaps one of the major hurdles we encounter with 'old guard' agency staff (although this is less a problem with CD providers than it is with MH providers). This becomes an issue when we must switch from the 'regular monthly check' from the State or other fixed contracts, to a 'fee-for-services-delivered' system. NOTE: Private practitioners have long ago dispelled the notion that providers will 'burn out' with more than 20 direct service hours. However, consider compensating program staff for increased productivity through workplace flexibility and incentive programs.**

**Program design under managed care often takes new twists that are unfamiliar to some professionals and Boards of Directors – e.g., Intensive In-Home Services for adolescents, out-of-office service delivery, more Intensive Outpatient Programs with less emphasis upon residential as a ‘standard’ treatment . . . true 24 hour availability and the need to extend telephonic response to ‘around the clock’ . . . the need to pass through some sort of external Utilization Review (UR) to obtain permission to treat or to establish the ‘medical necessity’ of the level of care . . . having to play ‘Mother May I?’ with the managed care company.**



**Many of these program augmentations are good, but there is also a caveat. Read on . . .**



## **Review of a CD Issue Related to ... Care Management Decisions**

**Please recall: Standardized Level of Care protocols (such as those now typically used all insurance companies) are believed by many to result in questionable clinical outcomes for chemically dependent consumers. Reason: These protocols may not adequately accommodate the CD population's inherent tendency to relapse repeatedly while they are on the road to recovery. What to do here? Encourage your state and Health Plan to engage in good Quality Management studies of outcomes for CD patients! And for your most relapse-prone clients – especially those who recycling in and out of detox frequently – ask for a 'Case Rate', where you can make treatment decisions more freely – where you 'hold the cards'.**

# Congratulations!

**You have completed Lesson 2 of Course 3B. You may complete the short quiz for this lesson either now or later. To reach the quiz link, simply close this internet page and you will be returned to your Courses and Quizzes page. Then click on Quiz 2, Course 3B.**

**You can take each quiz as many times as you want, until you pass it. There is no penalty for failing a quiz, and you may retake it immediately.**

**So either take the quiz now, or you may resume the course – your choice! To move on to the third and final lesson of this course, either just close this page and click on Lesson 3 or return to [My Home Page](#) at a later time.**

