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PSYCHOLOGICAL SERVICE DELIVERY IN THE MANAGED CARE ENVIRONMENT

2 HRS CEU for Psychologists

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WORKING WITH MANAGED CARE:

10 Constructive Tips in Dealing with Managed Care by Peter Barach via Compuserve:

1. When writing observable goals, some can be based on patient self-report (i.e. Patient will self-report reduced depression).

2. Provide realistic GAF scores on patients

3. Consider using SCl-90R and BDI to monitor progress without running up large testing fees

4. Carefully read procedure manuals and not the quirks of each that you belong to.
If it provides manual of clinical protocols (ie VBH) read to understand decision process

5. Don't consider case manager enemy

6. If the case manager is unreasonable, ask for information in nonthreatening way (research supporting their conclusion or approach) Have some citations of your own to counter argument.

7. Be OCD about keeping track of sessions and expiration dates Count down. Request additional sessions well before expiration

8. If denied inform patient of appeals process,

9. If the Managed care entity requires significantly more uncompensated time and paperwork with less pay: drop out.

10. Involve patients in understanding their insurance plan. Develop questions that they may wish to ask their insurance company

Further Recommendations by EJB

11: Obtain pre-approval and pre-intake insurance screens on everyone
12: Bill at least Biweekly
13: Bill Electonically
14: Bill for your time
15: Terminate noncompliant patients or repeated no shows
16: Document multiple diagnosis
17: Limit who you take
18: Get the best office help, pay them well, and send deadbeats to collections promptly

What to Consider in a Managed Care Contract

Adapted and expanded from APA Practice Directorate's Survival Guide for the 1990's: a Marketing Handbook for Psychologists (1992)

It is generally recommended that psychologists consult with an attorney experienced in health care business matters.

How financially stable is the entity?

What are the experiences of other providers?

Hold harmless clause. Relationship to malpractice carrier.

Procedures for termination of contract. Appeal rights and advance notice to patients.

How does this contract interact with other plans or agreements you have?

Understand administrative burdens, paperwork, collection of copayments.

Collection of fees, timely payment, policy regarding noncovered or denied services

Ethical standards of the company. Commitment to quality care.

Determine if the services requested are consistent with your standard practice or expertise.

How are chronic illness and special needs handled?

Determine how confidentiality is handled and reconciliation with State/Federal Guidelines and ethics.

Determine limits on practice prerogatives such as referral to other providers or services.

Procedures and nature of multidisciplinary interaction.

Understand Utilization Review Criteria. Are they acceptable?

Handling of phone consults, missed appointments, additional reports etc.

RISK MANAGEMENT IN MANAGED CARE

Paul S. Appelbaum, Legal liability and managed care. American Psychologist, 1993, 48(3) 251-257

In a managed care system clinicians are not always to provide care they feel would be ideal or even necessary. Applebaum outlined three duties:

1. DUTY TO APPEAL ADVERSE DECISIONS:

Clinician may have obligation to contest on the patients behalf denial of payment for treatment which is indicated. The duty to appeal adverse decisions was indicated in Wickline vs State of California. "The physician who complies without protest with the limitations posed by a third party payor, when his medical judgment would dictate otherwise, cannot avoid ultimate responsibility for the patients care".

Consensus is that at least an initial appeal is required. Further appeals should probably be pursued only after consulting with the patient in exploring other options and the likelihood of success.

2. DUTY TO DISCLOSE:

At the beginning of therapy you may wish to discuss the potential effects of managed care on the course of treatment. The possibility that therapy may be terminated before it is felt that therapeutic goals have been achieved or consolidated. Disclosure of the extent and nature of information the managed care entity may request should be discussed.

3. DUTY TO CONTINUE TREATMENT

When an emergency exists or the patient is acutely suicidal or unstable a duty not to abandon the patient exists. This must continue until the situation resolves or an alternative appropriate treatment is established. Referral to appropriate low cost or free treatment or appropriate termination must be established. This may involve a few to several sessions to consolidate treatment gains and direction to other resources if crises develop.

Varol v. BCBS of Michigan, 1989 "Whether or not the proposed treatment is approved, the physician retains the right and indeed the ethical and legal obligation to provide appropriate treatment to the patient".

Haas and Cummings in Mental Health Practitioners Gudie To Managed Care

referenced a Makenzie 1989 review with respect to recommendations regarding literature concerning which patients should be excluded for brief therapy

1. Unable to attend the process of verbal treatment (long or short term)
   i.e. Delirium, dementia, retardation, severe psychosis

2. Patients with diagnoses that require other treatments
   i.e. Acute panic disorder, major affective disorders, and schizophreniform

3. patients with characterological style that precludes enduring the psychotherapeutic work
   i.e. Those with history of repeated suicide attempts, alcohol abuse, chronic obsessional, or phobic patterns.

Goals may need to be very limited with some of these individuals.

REFERENCES

APA Practice Directorate's Survival Guide for the 1990's: a Marketing Handbook for Psychologists (1992)

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Lowman, R.L. and Resnick, R.J., Ed. The Mental Health Professional's Guide to Managed Care. American Psychological Association, 1994