

CE Course 2B

'They're Coming To Audit WHEN?' – The MCO's Authorization Process & YOUR Documentation In Client Records



Learning How Managed Care Companies Think . . . And Documenting Accordingly!

What Can Go Wrong In That Chart!

Avoid Those Claims Denials And Charge-Backs, Get the Approvals Your Clients Need.

THE GOALS FOR THIS COURSE

This Course 2B is NOT a primer to teach the detailed administrative procedures for obtaining and keeping an MCO's authorization to provide treatment in a Managed Care Model. Rather, we seek to make clear the meaning of 'A LEVEL OF CARE' and how it impacts the treatment you deliver.

We also focus upon how to do EFFECTIVE DOCUMENTATION of the treatment you do, within client records – a skill which can protect you from 'recoupment', i.e., the taking back of claims payments by the MCO (AFTER they have paid you) because of problems that they find in your clients' treatment records when they audit them.

We also address the essential principles for SUCCESSFULLY REQUESTING AUTHORIZATION OR REAUTHORIZATION for treatment for your clients.



Managed Care Is NOT an Issue Only in Public Health Care Programs. It Applies to Those in Private Practice, Too.

Many practitioners think that they won't be affected by the move to Managed Care – they believe that it only applies to Medicaid, Medicare, and the ACA (ObamaCare). NOT SO. Commercial (private) insurance carriers are already moving into this way of doing business with the providers on their 'panel'. So whether you work in a Community Mental Health Center or Block Grant Chemical Dependency Treatment Program or other agency setting – or in Private Practice – this information is relevant to you.

A note on terminology.

NOTE: Companies which are participating in this newly expanded approach to healthcare carry various labels - including Health Maintenance Organizations (HMOs), or Managed Care Organizations (MCOs), or Behavioral Health Organizations (BHOs), or 'Health Care Insurance Companies', or Health Insurance Exchanges (*'The Marketplace'* within ObamaCare's Affordable Care Act). In this mini-course, at times we may refer to any and all of these companies as 'MCOs', unless there is a specific reason to differentiate. And because most insurance companies are now VERY careful how they spend their money, we shall refer to this new cost-saving approach as 'Managed Care', regardless of who is administering the contracts.

. . . a note on terminology . . .

In addition, when we speak of 'controlling costs', what we say applies to most of the new federal Health Care Reform movement (known as ObamaCare or the Affordable Care Act) which was brought into law in March 2010. This is not approached from a political standpoint, but rather in terms of the intent to cut and control the cost of health care, and to make services available to more individuals – and to encourage some new ventures among companies which may have not been doing business before.

No one knows how the federal Health Care Reform movement will play out, or even many of the details within – except that whatever shape it takes, control of costs will be central. And that means more 'Managed Care'.

Lesson 1 of
Course 2B

Like It or Not, It's 'Disease Management' – Not Social Service

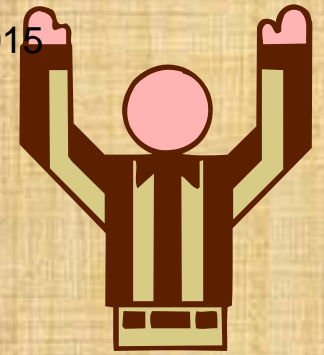
- **Managed Care is 'Medical Model' – and we must adapt what we write in charts, according to our contractors' philosophy. That philosophy is becoming increasingly 'medical' in orientation.**
- **'Medical' means TREATMENT – not simply social service or support. Health plans pay for TREATMENT which TARGETS DYSFUNCTION.**
- **When delivering health plan services to individuals with behavioral health diagnoses, we must think 'clinical' and 'treatment' and 'remediation of dysfunction' when we DOCUMENT – 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.

Does this mean what it sounds like? Are MCOs trying to change how we have 'always done' treatment – and how we document it? Well . . . yes.





TOUCHDOWN, FIELD GOAL
OR SUCCESSFUL TRY

Why are things changing? Could it have something to do with some of the goals of Managed Care? YES!

One of the primary goals of managed care is to control the rising cost of healthcare, a.k.a. **COST CONTAINMENT**.

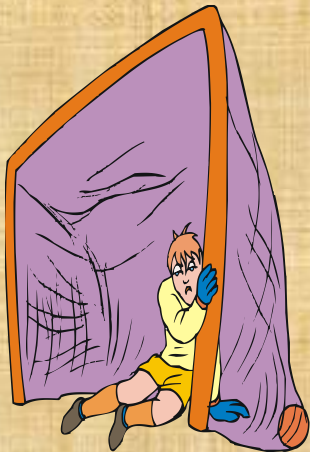
This means that who gets treatment – and how much of what type of treatment they get – had to change.

Managed Care also . . .


- Focuses upon the **REASON** for services and how much the client **NEEDS** the services.
- Offers consumers a broader choice of providers
- Seeks to improve **QUALITY** of care
- Promotes **INNOVATION** in delivery of services – ‘old hat’ is **OUT!**
- Seeks to improve outcomes for consumers (doing ‘good’ is not enough)

Implications of these new goals? Yes! Providers must alter how they usually operate and think, to be successful under Managed Care. Part of the change is in how we document what we do.

- **For anyone involved in healthcare: Fine tuning what we do and how we do it – and documenting the OUTCOMES of what we do – are the new watchwords. ‘Doing good’ is no longer enough.**
- **For all providers: We must not ignore the new requirements for documenting what we do for our clients. ‘Resting on our traditional laurels’ – in terms of how we deliver services and how we document it – places agencies and private practices in an extremely vulnerable situation.**




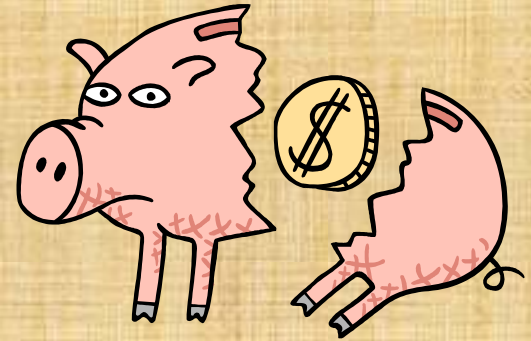
But what does 'reducing the cost of care' have to do with the new requirements for providers?

 An MCO or other such managed care company is typically 'at risk' of losing a great deal of money when it contracts with the State to provide such services as Medicaid. Thus it must do what it can to reduce how much money is spent on treatment. In other words, they must **PRIORITIZE** who gets treatment, and what they get, and for how long!

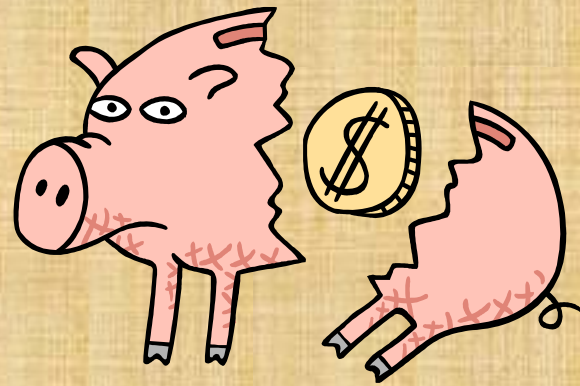


But why is the insurance company at risk of losing money?


 The MCO is given a **FIXED** amount of money which must last for the entire contract year. **BUT . . .** the MCO typically must provide **MEDICALLY NECESSARY TREATMENT** for **ALL** enrolled, eligible individuals in the health plan who show up for services . . . **NO WAITING LISTS ALLOWED . . .** no matter how many individuals appear for treatment, or how many times they appear. **SO . . .** how do they keep from running out of money?



For the MCO, the key to not losing money rests upon an assumption that **ONLY those who have a need for **MEDICALLY NECESSARY** treatment will get services!**



Who decides what is Medically Necessary?


 The key here is that the MCO – not the provider – decides which treatment is really **MEDICALLY NECESSARY**.

The 'worried well' and the 'early stage alcoholic' are disappearing from the managed care treatment scene, as money grows tighter. Only those who have a clear need for **MEDICALLY NECESSARY** treatment will be served past initial assessment and maybe a couple of sessions.



A Few 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 – especially if funds for behavioral health are stretched thin.

Managed Care Companies make these decisions through an **APPROVAL** process called **CARE MANAGEMENT** or **UTILIZATION REVIEW**. More on that soon.




Understanding How MCOs Think.


If you do not understand how the 'MEDICAL NECESSITY' criteria are applied to the consumers in your care, getting approval from the HMO to deliver care 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?**'


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 things can be somewhat subjective so it's best to be **ultra-clear!**




 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**),

More on how they make Care Management 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 the level of care will have to change!

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 a managed care plan where the MCO is 'at risk' of losing money. You must be clear, clear, clear when you talk to the managed care company about what is needed.**



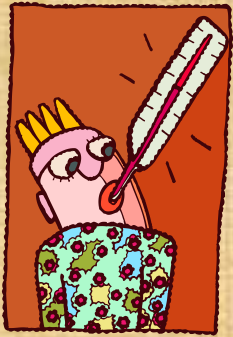
And if you can't clearly explain (verbally and in the client's record) the reasons why the client has a **MEDICALLY NECESSARY need for the services – and that you addressed these needs directly – you will not be paid for what you do.**




Or you may have to give the money back, following an audit.

How you explain the needs of the client and how he is responding to treatment is **EVERYTHING in managed care!**

You may need to explain to the MCO verbally or in writing – up front – what the needs are and why you are requesting a particular type of treatment. **AND then all of this must **ALWAYS** be reflected in writing – in the client's chart or treatment record.**



 Remember that MCOs 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 it having a **POSITIVE IMPACT** up on his condition?

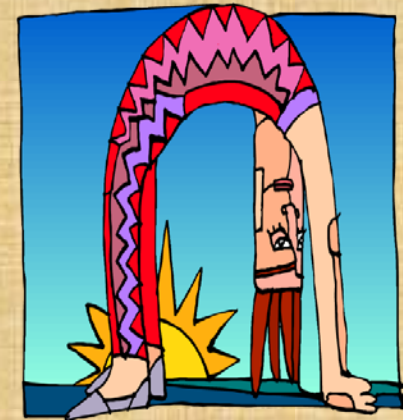
For MH clients, MCOs **DO NOT** look simply at whether or not it would be 'helpful' or 'nice' for the individual to have a certain type of treatment, or whether the patient simply 'wants it'. And they **DO NOT** base decisions upon a plea that 'we have always done it this way.' Many of the 'old ways' have been discarded or radically modified, in this day of 'short funds' and more rigorous management of treatment.



For the CD client, managed care companies 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 most certainly DO NOT base decisions upon a plea that 'we have always done it this way,' or that '28 day programs are part of our tradition.' 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 and basic services is really justified – particularly during any given year.

Bottom line, the managed care company's decisions may contradict a provider's own PROFESSIONAL BELIEFS about 'how much' of 'what' is needed at any given point in time. For example, the managed care company will probably limit how long an individual remains at the more expensive levels of care.

- **How? The MCO may 'step them down' to a lower level of care (less intensive and less expensive) long before the provider (in the past) would have done so. Is this really 'bad'? Not necessarily. It may just be 'different'.**



Concerns About The 'Cost Control' Element

With the coming of Managed Care to several states, a decade ago the National Alliance for the Mentally Ill (NAMI) expressed concerns that the emphasis would be placed upon the element of COST CONTROLS instead of upon the element of CARE. And of course, the State legislatures typically ARE most concerned about the element of COST, as their primary reason for implementing a managed care model.

NAMI's concerns were first clearly expressed in 'Grading the States 2006: A Report on America's Health Care System for Serious Mental Illness.' An example is this statement (and similar statements since then) in their 2006 *Report Cards of the States*:: "Managed care models sometimes turn into *managed cost models*."

Concerns of NAMI . . .

And further, NAMI has reflected the thought that managed care companies' corporate emphasis upon *profit* could result in harm to the delivery system [and this would apply to Mental Health and to CD-AOD.]

For example, one comment made in the 2006 report is that too often " people's needs are sacrificed in favor of private profit incentives." That concern has not changed, in terms of how NAMI and many other behavioral health advocates see the potential problems.

However, the Principles of the Affordable Care Act Have the Support of NAMI.

Says NAMI on its website:

“The Patient Protection and Accountable Care Act (ACA) addresses many of the challenges people have in getting and keeping health care coverage. [There are] key provisions of the law that offer meaningful benefits to individuals living with mental illness and their families.

NAMI identifies the following ‘Patient Protection’ provisions of the ACA as particularly positive for persons with mental health and addiction disorders:

- **Pre-existing Medical Conditions – care cannot be denied based upon such.**
- **Extension of Dependent Coverage**
- **Prohibits lifetime limits**
- **Prohibits annual limits for certain types of plans**

And do the DOCUMENTATION requirements collide with the provider's ethics or own beliefs about what is 'appropriate' to write in a client's chart? Maybe!

Treatment documentation requirements under Managed Care are often a turn-off to private practitioners and program staff. MH PROVIDERS who have been 'raised up' in strength-based models have particular problems with the documentation requirements. Why? They prefer to avoid written documentation of the individual's 'illness' or 'symptoms' or 'problems' or 'weaknesses'. And this can be a problem. Why?



Managed Care Companies are PURCHASING 'problem and disease management' – not 'strengths identification' (although we UTILIZE strengths of our clients in everything that we do).

. . . and the requirements may be noxious to many CD providers.

This is especially true for those CD Counselors whose philosophy and treatment approach comes from a didactic, educational model.



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 (re)train to WRITE in a way that is 'clinical' and 'diagnostic', and oriented toward 'disease management'.



A CD Issue Related to Care Management Decisions

Special Note: Standardized Level of Care protocols (such as those typically used by Insurance Companies and MCOs in their Care Management process) are believed by many to result in 'questionable clinical outcomes' for Chemically Dependent consumers. Reason: These 'Care Management' protocols may not adequately accommodate the CD population's inherent tendency to relapse repeatedly while they are on the road to recovery.



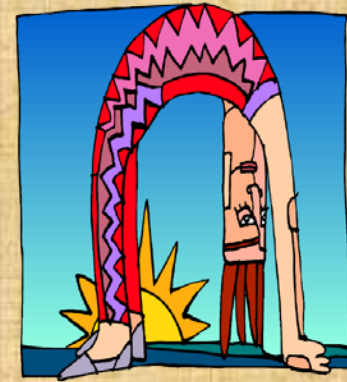
A CD Issue Related to Care Management Decisions . . .

What to do here? For your most relapse-prone clients – especially those who are 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’. (More about that in the second half of this course.)



Treatment documentation requirements under managed care 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 statements' or similar comments which you might later need to explain in court if called to testify on a matter related to the case.

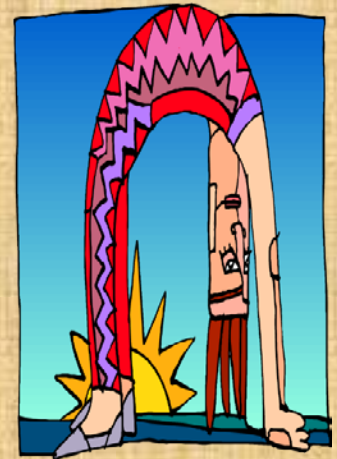
MCOs ALSO place a great deal of emphasis on whether or not the client will BENEFIT FROM additional treatment. For both CD clients and for Seriously Mentally Ill (SMI) clients, this may be especially difficult; your documentation needs to communicate clearly why and how he will benefit from additional CD or MH treatment, despite repeated relapse.



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 MCO 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. 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.



Can you have problems with payment of your claims, even after the MCO has paid you for what you did for the client? Yes indeed!




Assuming that 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 MCO, 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. We'll talk about how to prepare for audits, soon.

Why Are MCOs So 'Picky'?



WHY are the MCOs 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 need of the enrollees is **GREAT**. Obviously, the use of the limited funds by **YOU**, the provider, must be carefully **MONITORED** by the MCO.



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 what you billed them for correspond with what is DOCUMENTED in the consumer's record? If not, there will be problems!





Congratulations!

You have completed the 1st of 3 'lessons' in Course 2B. You may complete the short quiz for this lesson either now or later. To reach the links for the quizzes and the lessons, simply close this page. You will see your list of Study Guides and Quizzes displayed in the previously opened window.

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!