Navigating Managed Care Systems in Minnesota, A Guidebook for New Providers

A Summary Paper

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Purpose and Significance of the Project

One of the realities of becoming a mental health provider in Minnesota is dealing with insurance companies and managed care organizations (MCOs). For new providers, regardless of if they go into private practice or work for a clinic, they are likely going to have to learn how to deal with insurance companies and MCOs in order to get referrals, authorizations, and payment for services they are providing. There is little information in most graduate programs about insurance companies and how to work with them. New providers often find themselves thrown into the world of insurance requirements without a solid idea of how to deal with those requirements. That can be a cause of stress, frustration, and can hinder provider’s ability to provide quality care for their clients.

This writer has worked for a managed care organization for over 10 years. Having had that background and then going through graduate school has been an eye opening experience in terms of the training and the mindset that many new providers leave school with. Many providers become frustrated and upset when trying to understand the different insurance company requirements. Because there is not adequate training about insurance companies, providers can become unwilling to work with insurance companies or otherwise spend many hours trying to understand the different requirements. It is this writer’s opinion that conflictual relationships between insurance companies and mental health providers have a negative impact on client care.

This writer may be biased because of experience, but is of the opinion that the more providers know about insurance companies or MCOs; what different requirements are, why they are in place, and what kind of questions to ask, the easier time they will have providing care to
their clients and being reimbursed for it at the same time. It is the goal of this writer to help new providers understand and navigate through managed care companies in Minnesota.

Definitions

The following are terms related to health insurance, managed care, and behavioral services that may be used throughout the project. To understand how to navigate through managed care systems, one first needs to be comfortable with general insurance definitions and understand what kind of different insurance companies exist. There will be further definitions given throughout the project.

Carve Outs. A payer strategy in which a payer separates or carves out a portion of the benefits and hires an MCO to provide these benefits (retrieved from http://www.mcrres.com/mcrdef.htm).

Fee-for-service. A method of reimbursement based on payment for services rendered. Payment may be made by an insurance company, the patient, or a government program such as Medicare. Payment for specific amounts for specific services rendered (retrieved from http://www.mcrres.com/mcrdef.htm).

Health Maintenance Organization (HMO). A nonprofit organization which provides comprehensive health maintenance services or arranges for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee (retrieved from http://www.health.state.mn.us/clearinghouse/glossary.htm).

Health Plan. A policy of health insurance issued by a health maintenance organization, an insurance company, or other authorized entity (retrieved from http://www.health.state.mn.us/clearinghouse/glossary.htm).
Managed Care. Strategies used by health plan companies to control the cost of providing health care while providing high quality services (retrieved from http://www.health.state.mn.us/clearinghouse/glossary.htm).

Medicaid. A health care program for people who meet certain income and other guidelines, paid for by federal and state dollars. In Minnesota, this program is called Medical Assistance (retrieved from http://www.health.state.mn.us/clearinghouse/glossary.htm).

Medicare. A federal health insurance program for people over 65 and for certain people with disabilities (retrieved from http://www.health.state.mn.us/clearinghouse/glossary.htm).

Minnesota Care. A health insurance program for low income Minnesotans who meet income and other eligibility guidelines (retrieved from http://www.health.state.mn.us/clearinghouse/glossary.htm).

Point-of-Service Plan (POS). Also known as an open ended HMO, POS plans encourage but do not require members to choose a primary care physician (PCP) who acts as a gate keeper. Members may opt to visit non-network providers at their discretion but then often pay higher deductibles and co-pays (retrieved from http://www.mcres.com/mcrdef.htm).

PMAP. Prepaid Medical Assistance Program. The Minnesota Department of Human Services contracts with health plan companies to provide services for people enrolled in Minnesota Care or receiving Medical Assistance (retrieved from http://www.health.state.mn.us/clearinghouse/glossary.htm).

Preferred Provider Organization (PPO). Some combination of hospitals and physicians that agree to render services to a group of people. The services may be furnished at discounted rates and the insured population may incur out-of-pocket expenses for services outside of the PPO (retrieved from http://www.mcres.com/mcrdef.htm).
Self-insured Plan. A program of providing group healthcare coverage with benefits paid entirely by the employer rather than by an HMO or insurance company (retrieved from http://www.health.state.mn.us/clearinghouse/glossary.htm).

Third-party Payer. Anyone paying for the health care who is not the patient (first party) or the caregiver (second party). An organization that provides administrative services for insurance companies (retrieved from http://www.health.state.mn.us/clearinghouse/glossary.htm).

Literature Review

Insurance authorizations and participation in managed care organizations (MCOs) are often a required part of being paid for providing mental health services. How insurance authorizations and MCO guidelines and requirements are understood by mental health providers/practitioners/counselors/therapists (these terms will be used interchangeably through this literature review) could potentially have either a positive or negative impact on client care and outcomes. This literature review is focused on how the relationship between mental health providers and MCOs impacts the quality of care received by clients seeking help for emotional and behavioral problems. There are two assumptions in this review. One, insurance authorization and oversight of mental health services by MCOs can have a positive impact on client outcomes only when providers understand and accept the goal of the managing entity. And two, finding ways to increase the understanding and collaboration between MCOs and mental health providers will increase access to care and quality of care for clients.

MCOs and Mental Health Providers

What are MCOs?

MCOs are a part of the medical industry. To understand the impact they have on mental health providers and on the quality of behavioral services, one has to first understand what
MCOs are and how they interact with providers. What are MCOs, and what do they do? Generally speaking, MCOs enforce insurance standards for providing behavioral services. According to Mechanic (1997), managed care consists of a variety of structures, processes and strategies designed to monitor, review, and guide processes of care. MCOs may impose various restrictions on mental health services; number of session limits, cost limits, and/or medical necessity and standards of practice (“quality of care”) standards to determine if services are granted and whether they are effective. They form relationships between payers, providers and consumers to influence and monitor services and outcomes. (Braun & Cox, 2005). The objectives of MCOs in general are to reduce costs, prevent unnecessary utilization, reduce inappropriate utilization, and ensure adequate access to quality services (Bouchery, 2003).

The term managed care was coined in the 1980’s and the most common kind of MCOs are HMO’s (health maintenance organizations) and PPO’s (preferred provider organizations) (Bobbitt, Marques, & Trout, 1998). The idea of an HMO started as early as the 1920’s, but the phrase HMO was not coined until 1970. Most early health ‘insurances’ started to help cover health care for groups of people; workers and families in the lumber, mining, and railroad industries. Enrollees would pay a set fee to physicians who would then deliver care in terms of the agreement set up (retrieved from http://www.thci.org/downloads/BriefHist.pdf). Early prepaid health plans developed through the 1920’s, 30’s, 40’s but were opposed by the AMA and didn’t start to get significantly bigger until the 1970’s when issues such as cost containment, coverage for the uninsured, access to services for the poor and minorities, consumer rights, and efficient delivery systems all became larger issues and political issues (Bobbitt et al., 1998).

MCOs may try to control costs associated with behavioral services in several ways. They generally only allow providers who have joined their network to see the clients they serve. They
may require a provider to obtain certification for treatment; some MCOs grant ‘pass through visits’, blanket authorizations for a certain number of sessions before certification is needed, or they may not. Some MCOs may use a telephonic review system in which the provider must call to speak with a reviewer about how the client meets medical necessity criteria, others may require treatment plans outlining criteria and goals/interventions being worked on (Keefe & Hall, 1999). Different MCOs have different guidelines.

Why MCOs and Mental Health Providers Have to Interact

Why should mental health providers be concerned about MCOs? Why do they need to care? In general, mental health providers are trying to help people with mental illness. Mental illnesses and substance abuse impose substantial burdens on patients, employers, and health care systems (Eselius, Cleary, Zaslavsky, Huskamp, & Busch, 2008). For professionals that are in the behavioral health industry, the reality is that managed health care regulations affect the manner in which counselors provide and deliver service, managed care seems to be here to stay and will continue to have both positive and negative effects on providers and consumers (Braun et al., 2005).

Managed care has profound effects on health and mental health service delivery in the United States (Claiborne & Fortune, 2005). According to Braun et al. (2005), managed mental health care has significantly affected how emotional and behavioral services are provided. Managed care guidelines determine whether and how providers deliver services and whether those services will be reimbursed. In addition, thousands of people are joining managed care plans each day, and the mental health benefits of millions of Americans are reimbursed by MCOs (Keefe, 1999).
Some practitioners are bypassing managed care but most are finding ways to practice responsibly within a managed care system. Most providers do not have the option to work without managed care. Some providers work outside of the insurance industry by having clients pay out of pocket for their mental health services. It is then up to the client to seek reimbursement from the insurance company for the services. If paying for services is not a problem for certain clients, this can be a viable option for them and can feel more confidential. However, this option can also be burdensome for the clients. Many clients have neither the resources nor the inclination to pay for mental health care out of pocket (Danzinger et al., 2001). It seems that to a significant degree, MCOs and mental health providers have to co-exist to serve people with mental health issues. Knowing this, the next question to answer then becomes, how do MCOs and mental health providers currently co-exist?

**Relationship Between MCOs and Mental Health Providers**

As MCOs and providers are to some degree, both trying to serve the same population, how do they interact? How do they work together? What opinions do they have of each other? What do providers want from MCOs and what do MCOs want from providers? According to Clairbourn et al. (2005), providers are pressured by MCOs to demonstrate that their treatment approaches are effective and cost-efficient. Insurance plans are pressured by government, advocacy groups and accreditation entities to promote quality improvement efforts. According to Tompkins & Perloff (2004), to participate in managed care, providers must agree to the resource allocation, sometimes accept financial risk, and often accept limits on number of clients serviced and limits on duration and intensity of services per client. Does this work well for providers and for MCOs?
Positive Interactions Between MCOs and Mental Health Providers

There is little information about positive relationships between MCOs and mental health providers. This could indicate either that there are not many examples of positivity between the two, or that positive examples are not focused on in the current literature. Some providers acknowledge that managed care has the potential to improve access to care and the effectiveness of care. “The emphasis on the assessment of outcomes can lead to improved standards for treatment and a more effective matching of services to individual needs” (Scheid, 2000, p. 715).

Some providers report feeling that managed care has made them think more about outcomes, progress, and patient satisfaction, more goal setting and follow through (Scheid, 2000). Also, a potential benefit for providers that use MCOs is increased referrals (Keefe, 1999). Goodman (1997) found that many mental health providers work in managed care and believe it to be viable and acceptable or even preferable to previous approaches to mental health delivery, but specific numbers are not given. There are many more examples of negative relationships between MCOs and mental health providers in the literature.

Negative Interactions Between MCOs and Mental Health Providers

There are many strong negative opinions about managed care organizations from mental health providers, and many problems that providers' experience. Most mental health providers strive to meet MCO regulations, but they do not agree that managed care is effective. “The majority of mental health counselors perceive MCO requirements as a negative influence on their practice” (Braun et al., 2005, p. 431). Providers can be dissatisfied for a variety of reasons. For example, providers can be dissatisfied because they were denied access to MCOs or because they experienced a provoking encounter with MCOs.
There can be also be ethical and legal dilemmas involving informed consent, confidentiality, client autonomy, competence, treatment plans, and termination that had not existed prior to the introduction of managed health care systems (Braun et al., 2005). Providers report that managed care has negatively affected their work with clients and that the protection of the confidentiality of client information is the most troublesome issue (Danzinger & Welfel, 2001). Client openness may be increased without MCO requirements of sharing information.

Clients do not know who is seeing their information at managed care companies and do not know anything about who is approving or denying their services. The managed care reviewer is someone independent of the therapeutic relationship, and does not know the client either. Patients may shy away from seeking treatment when an unknown third party is involved; especially if that third party is associated with their human resources department or EAP program (Corcoran, 1994). This may seem unfair or frightening to clients who are concerned about their personal information being seen and judged by someone they do not know or interact with. Providers may feel that this could be harmful to the therapist/client relationship and could potentially have a negative impact on the client developing trust and rapport.

Another issue that providers may face is trouble getting an authorization. DSM codes may be denied for insurance reimbursement for different reasons. Managed mental health care plans may deny benefits and insurance reimbursement for adjustment disorders, for disorders typically requiring long term counseling, or when the only diagnosis is on Axis II or a V code. “When insurance reimbursement is denied because certain DSM codes are not approved, mental health counselors, clinical counselors, social workers, and psychologists may intentionally misdiagnose mental disorders in order to receive insurance reimbursement for delivers of
services” (Braun et al., 2005, p. 430). This creates not only frustration for the provider but can lead to serious ethical issues and considerations.

Some providers also feel that they have lost their autonomy with managed care. Because providers are accountable to MCOs, they are not free to plan and implement treatment independently (Danzinger et al., 2001). Scheid (2000) indicated that managed care for providers has led to the loss of their professional prerogative and undermined their professional autonomy. Providers may feel that they have to “sell” their services, and that decisions made about care are made by business and financial specialists rather than clinical directors. “Managed care subjects the treatment decisions of providers to increased managerial, financial, and bureaucratic scrutiny” (Scheid, 2000, p. 718).

Finally, providers report little training in the managed behavioral health care industry (Keefe, 1999). Some providers report that managed care has increased the amount of paperwork and time on the phone getting authorization, documentation requirements can feel burdensome, and providers may have to deal with four, five, or more different managed care companies at a time (Scheid, 2000). If providers have little training in dealing with MCOs and then have to deal with different MCO companies with different requirements, it could easily feel overwhelming and burdensome to try and figure out how to navigate through the systems.

Mental health providers have some strong issues with MCOs and the relationship between the two entities seems to be more negative than positive. Knowing that MCOs and mental health providers have to interact, the final question to consider is about how MCOs, mental health providers, and the relationships between the two impact the client experience of receiving mental health services.
Client Care and Outcome

Mental health providers are by nature supposed to help people cope with mental illness. How do they know if they are successful? What does quality of client care actually mean? What is a positive outcome and what is a negative outcome? Do MCOs affect the outcome of client care? If so, do providers have an obligation to then work with MCOs? How does the relationship between MCOs and providers impact outcomes? These are some of the final questions to answer, and they are not easy questions. Quality care measures can include number of hospitalizations, length of stay, and utilization rates for different services (Bouchery, 2003). Scheid (2000) noted that it can be difficult to assess treatment effectiveness. Bouchery (2003) noted that general available literature on quality of care is limited, detailed studies of patient clinical outcomes and functional status is not available.

How MCOs Impact Quality of Care

MCOs can have either a negative impact on quality of care, or a positive impact. In the research, there is more discussion about the potential positive or negative impacts rather than the actual impacts. Both will be examined, first some of the possible negative impacts. A common criticism of the traditional managed care model is that it is not suited for treating people with chronic mental health conditions (Warren, Nelson, Mondragon, & Burlingame, 2010). Managed care can work well with mainstream populations, but there is a question about if they have the capacity to work well for people with complex needs and multiple problems (Mechanic, 1997). MCOs often collect quality data over time on different providers, they often adopt ‘best practice’ policies based on evidence based guidelines and consensus among clinicians (Tompkins et al., 2004). This is kind of a one size fits all policy which may mean that difficult or unique clients may not fit into MCO guidelines for treatment.
There are also positive impacts on quality of care and potential positive impacts. Managed care can potentially widen access to a broader treatment population and can lower cost to the clients. Another benefit of managed care is the increased accountability of providers for the services they are providing, and a limit of waste and abuse by providers (Scheid, 2000). MCOs report that they use the most up to date research on psychotherapeutic effectiveness (Keefe, 1999). Managed care has the potential to improve mental health practice, many practitioners resist guidelines and scientific findings preferring their own clinical experience, but managed care can put systems in place to measure performance to enforce adherence to standards (Mechanic, 1997). “Given the increased emphasis in managed care on providing quality services while minimizing costs, the average duration of treatment in managed care is often shorter than traditional community mental health settings” (Warren et al., 2010, p. 146).

There is some research that supports these positive findings. Warren et al. (2010) did a comparison of initial symptom levels, patterns of change, and final outcome in a community mental health system and a managed care organization that serve families in the same geographic area. The study found that the average rate of positive change was significantly steeper in the private managed care setting than in the public community mental health setting. Also, the study found that negative outcomes were more common in the community mental health setting. Cook et al. (2004) found that enrollment in managed care was associated with lower inpatient/residential, psychiatric and non-traditional service utilization, but with higher or same outpatient utilization. A study of Nebraska’s Medicaid managed care program found that managed care is associated with reductions in costs and a rapid decline in inpatient admission and utilization, with general maintenance or increase in outpatient services (Bouchery, 2003).
There are measures in place for MCOs that hold them to quality standards and collect quality data. Public reports about patient experiences and quality of care are being used more frequently by accreditation agencies like the National Committee on Quality Assurance or NCQA. “Policy makers and payers have become interested in assessing quality by comparing the experiences of patients across behavioral health organizations in an effort to increase accountability and better inform quality improvement efforts” (Eselius et al., 2008, p. 2030). NCQA requires providers of behavioral health to document quality of their work, client satisfaction, demonstration of clinical outcomes, and adherence to specific care and guidelines (Braun et al., 2005).

The fact of review itself probably may serve as a deterrent and induce clinicians to think more carefully about their treatment plans (Mechanic, 1997). Outcome measures can demonstrate the value of mental health services to skeptics and provide information that can be used by clinicians. Outcome measures can ensure that people with mental health needs receive effective, efficient, and high quality care (Lyons, 1997).

**How Mental Health Providers Impact Quality of Care**

There is little information about quality of care for mental health providers outside of managed care systems. This could indicate that the burden of showing quality or measuring outcomes lies with the MCOs. For providers that do not take insurance, they have no obligation to prove to anyone that their methods are successful, so long as they are able to continue to see clients. Keefe (1999) did note that when psychiatric care was unregulated, there was little incentive for providers to modify the services being provided.
Summary

Considering all of the above information about MCOs, mental health providers, and quality of care, what does this all mean? MCOs exist and are working on ways to improve quality. Mental health providers may not want to work with MCOs but many cannot avoid doing so. Although providers may have negative feelings about MCOs, the question then becomes, how can providers and MCOs work together to best serve clients? A common theme in the research was about education for providers and for MCOs.

MCOs and provider organizations can benefit from education about problem areas if they make appropriate modifications (Tompkins et al., 2004). If providers know what MCOs expect and MCOs work with providers to make the process less burdensome and to help providers understand the purpose of the MCO guidelines, it may help make the process smoother for both and thus better for the client. Mental health providers have trouble communicating effectively with MCOs. They must meet medical necessity criteria but MCOs can vary in how they define medically necessary treatment (Keefe, 1999). According to Danzinger et al. (2001), professional associations may need to take a more active role in providing mental health counselors with better resources for coping with ethical dilemmas, frequently asked questions, or a consultation service for ethical issues, questions, and problems.

Managed care entities and providers share an orientation toward improved client functioning but they differ on the extent and depth of this improvement (Scheid, 2000). “Ongoing training by managed behavioral health care organizations that stress what is expected is important” (Keefe, 1999, p. 167). “Students need a basic grounding in the principles of managed care if they are to practice successfully in today’s service environment” (Claibourne et al., 2005, p.193). “Utilization review is only as good as the systems in place for carrying it out
and the capabilities and thoughtfulness of those who serve as reviewers and who supervise their
decision making” (Mechanic, 1997, p. 51). Providers and the health care industry should engage
in a sustained and searching dialogue that informs about the choices at hand and establishes
criteria for ongoing evaluation (Wooley, 1993).

In doing this research project, I was surprised by the amount of literature available on
managed care and even more surprised how heated and subjective most of the research was.
This is a topic that people feel very strongly about and I feel this justifies further exploration
about how these two groups of people can work together for a common cause of helping people
with mental illness. I feel even more strongly than before that training for mental health
providers needs to involve some education on the business aspects of providing behavioral
services.

**Contracting and Credentialing**

**Definitions**

*Contract*. A legal agreement between a payer and a subscribing group or individual
which specifies rates, performance covenants the relationship among the parities, schedule of
benefits, and other pertinent conditions. Usually limited to a time period and renewal
agreements thereafter (retrieved from [http://www.mcres.com/mcrdef.htm](http://www.mcres.com/mcrdef.htm)).

*Credentialing*. The review process used by an insurer or health plan to determine which
health care providers are qualified to provide services to health plan members. Usually the
provider license, certification, malpractice, and history are examined (retrieved from
[http://www.health.state.mn.us/clearinghouse/glossary.htm](http://www.health.state.mn.us/clearinghouse/glossary.htm)).
Network. A group of health care providers that form an affiliation and contract as a group with an HMO or insurer (retrieved from http://www.health.state.mn.us/clearinghouse/glossary.htm).

Nonparticipating Provider. A health care provider who is not under contract with an insurer or HMO (retrieved from http://www.health.state.mn.us/clearinghouse/glossary.htm).

Participating Provider. Health care provider who is under contract with an insurer or HMO (retrieved from http://www.health.state.mn.us/clearinghouse/glossary.htm).

Navigating through MCOs involves several aspects: contracting and credentialing, authorization, and billing or claims payment. Contracting or credentialing is the first step – in order to see clients with different insurance types, providers must first become part of the participating network of the different insurance companies.

There is a difference between contracting with an insurance company and becoming credentialed by them. Credentialing is a specific process for which an application is required that goes through work history, specializations, education, and specific questions related to professional history. This is the process insurance companies and MCOs use in order to determine if someone is appropriate to become a provider. If there have been any board actions or legal issues that a provider has had, those will have to be disclosed and potentially defended.

Contracting is an agreement between the provider and the insurance company or MCO about how services will be provided, what the expectations and requirements are, and what the reimbursement will be. Some companies require contracting only, and some require both contracting and credentialing.

Credentialing is a long process. It can take several weeks to several months to complete. This is important to keep in mind if a provider is planning to start seeing clients right away in a
setting; providers generally cannot get paid for services until they have completed the credentialing or contracting process.

There are several other things to keep in mind about the process of becoming an in-network provider. There are a lot of mental health providers in Minnesota. In the metro area especially, there are floods of providers in certain areas. One way to make it more likely that you will be credentialed, is to have an area of specialization. For example, there are probably hundred’s of private practitioners in Edina. If opening a private practice in Edina, unless a provider has a specific area of specialization, many insurance companies or MCOs may not have a business need and will not process the application. Areas of specialization can include things such as: speaking foreign languages, treating specific religions or cultures, treating less common disorders, treating underserved geographic areas, or offering crisis/evening/weekend appointments.

Once a provider has become contracted or credentialed, they will need to go through a re-credentialing process. This usually happens every 2-3 years and involves sending in another form and possibly some other paperwork (like updated malpractice insurance). It’s important to read the contract and any correspondence that comes from companies that providers may contracted or credentialed with. The contract and contract updates may contain specific information that could be important about billing or service requirements.

Finally, contracting and credentialing may or may not transfer from a clinic to a private practice. If a provider becomes credentialed while working for a clinic and then moves to a different clinic, they may need to re-apply or they may not to. If a provider works at a clinic and also has a private practice at the same time, the clinic contract/credentialing may cover the provider at your private practice or it may not. It’s important to be current on what different
insurance companies require in terms of this, and it is the provider’s responsibility to know what they need to do to be able to keep seeing their clients should they move clinics or move to a private practice.

**Authorizations and Review**

**Definitions**

*Benefits.* Specific areas of a health plan's coverage that make up the range of medical services that a payer markets to its subscribers (retrieved from http://www.mcres.com/mcrdef.htm).

*Case Management.* The process by which all health-related matters of a case are managed by a designated health care professional (retrieved from http://www.mcres.com/mcrdef.htm).

*Concurrent Review.* Review of a procedure or hospital admission done by a health care professional other than the one providing the care (retrieved from http://www.mcres.com/mcrdef.htm).

*Continued Stay Review.* A review conducted by an internal or external auditor to determine if the current place of service is still the most appropriate to provide the level of care required by the client (retrieved from http://www.mcres.com/mcrdef.htm).


*Covered Services.* Healthcare services that will be paid for in part or whole, by an insurance plan. A covered benefit must always be medically necessary, but not every medically
necessary service is a covered benefit (retrieved from
http://www.health.state.mn.us/clearinghouse/glossary.htm).

Exclusions. Charges, services, or supplies that are not covered under an insurance policy
(retrieved from http://www.health.state.mn.us/clearinghouse/glossary.htm).

Medically Necessary Care. Health services that are appropriate for a given diagnosis or
condition (retrieved from http://www.health.state.mn.us/clearinghouse/glossary.htm).

Peer Review. Mechanism used to evaluate the quality of health care services (retrieved

Prior authorization (also called Preauthorization or Precertification). Approval of a
health care service or medication before it is provided in order for the health plan to cover the
expense. A method of monitoring and controlling utilization by evaluating the need for medical
service prior to it being performed. Obtaining approval as to the appropriateness of a service or
medication. This process does not guarantee coverage or ensure that benefits will be paid
(retrieved from http://www.health.state.mn.us/clearinghouse/glossary.htm).

Retrospective Review Process. A review that is conducted after services are provided to

Utilization. Use of services, usually done in terms of dollar expenditures (retrieved from

Utilization Review. A determination of appropriateness and effectiveness of medical
treatment received or to be received by a patient (retrieved from
http://www.health.state.mn.us/clearinghouse/glossary.htm).

Once a provider has become part of an insurance company or MCO and completed the
credentialing process, they can then start seeing clients with that insurance type. However, the
process is much more complex than just doing therapy. There are several things that need to be considered when seeing clients include what services are covered, what kind of authorization is needed, and how to get that authorization.

Unfortunately, all the different insurance companies do not have the same covered services, nor the same process for getting authorization for services. It is very important to have a way of tracking information for different insurance companies or MCOs. Some providers may work in a clinic where administrative staff does most of the insurance work. However, for providers in private practice they are responsible for knowing what the differences are and responsible for getting the appropriate authorization for services provided. Even for providers that work in clinics, it is a good idea to have knowledge of what all the different requirements are as it is ultimately their responsibility to make sure those requirements for authorization and charting are met.

In this writer’s experience, there are several ways that providers can keep on top of the different insurance and MCO requirements. First, by taking the time to learn the different requirements of the major companies. Second, finding a way to keep track of the different requirements. If providers can find a way to understand and keep track of/monitor the requirements for different companies, as soon as they get a new client they will know what to do and can focus on treating the client as opposed to figuring out how to get an authorization. This writer has created several forms that will be included at the end of this section that are intended to be helpful examples of ways to keep track of different elements related to insurance authorizations.

How do providers find out what the different insurance requirements are? There are several ways. In Minnesota, for all of the clients that are on a PMAP or state funded insurance,
the Minnesota Department of Human Services (DHS) creates the rules and regulations. For commercial insurance plans, they generally create their own rules and regulations. Becoming familiar with DHS guidelines is probably the best way for providers to start becoming familiar with the authorization process and requirements as the DHS guidelines tend to be the most particular.

For the other insurance companies, it is a matter of reading the provider handbook, finding the authorization requirements and then keeping current on updates and changes. Most insurance companies and MCOs have websites that have their level of care guidelines, current requirements, and forms, and most of them send out correspondence when changes are made. For all insurance companies, it is also a matter of asking for help and clarification when requirements are not clear. In this writer’s experience, many providers do not take the time to ask questions up front, they try to just guess as to what requirements are or send lots of documentation in hopes that what they are sending will suffice. If providers would take the time up front to spend some time asking questions and becoming familiar with what is needed, it would likely save them much time and frustration when later trying to get authorizations.

Some companies do not manage outpatient services at all, others manage them very closely. Most companies require some kind of documentation or treatment plan at some point to give an indication what is being treated and how it is being treated. DHS has guidelines about how soon the diagnostic assessment has to be completed, what progress notes should contain, what treatment plans should contain, and how often treatment plans should be updated. Most other plans have similar requirements or defer to DHS guidelines. If providers do not adhere and comply to the requirements of an insurance company and are audited by that company, they run
the risk of becoming removed from the network or having to pay back money paid for therapy services.

For whatever kind of treatment plan or documentation that has to be provided to insurance companies or managed care organizations, get an idea of what the company is looking for and fill out their forms completely. Some companies may want to always see information about measurable treatment goals. Others may be more concerned with coordination of care. If a provider knows that company X always wants to see documentation of family involvement or a medication evaluation, they can always document this when sending information to that company and avoid having to be asked about it, they will likely get an authorization quicker and more painlessly.

Remember that all the insurance company is seeing is what you send them, and if pieces are missing or not fully addressed, it will likely cause problems in processing the request. A provider may know that their client has signed a safety contract for their suicidal ideation, but if they document suicidal risk with no indication that it has been addressed in treatment, the insurance company may question them. This writer can give some other examples, for example if the client is given a diagnosis of an anxiety disorder but the current symptoms reflect only depression. If the documented GAF score is significantly higher than the current symptoms or levels of care indicate (like seeing a client two times a week but giving them a gaf score of 80). Later sections in this project will show specific examples of requirements and forms, and will give additional tips and advice about prior authorizations.
Billing

**Definitions**

*Claim.* A request a healthcare provider makes to the health plan to pay for a health care service provided (retrieved from [http://www.health.state.mn.us/clearinghouse/glossary.htm](http://www.health.state.mn.us/clearinghouse/glossary.htm)).

*Fee Schedule.* A listing of accepted fees or established allowances for specific medical procedures. It usually represents the maximum amounts the program will pay for the specified procedures (retrieved from [http://www.mcres.com/mrdef.htm](http://www.mcres.com/mrdef.htm)).

*HCFA 1500.* The Health Care Finance Administration’s standard form for submitting physician services claims to third party insurance companies (retrieved from [http://www.mcres.com/mrdef.htm](http://www.mcres.com/mrdef.htm)).

*UB-92 Uniform Bill 1992.* Bill form used to submit hospital insurance claims for payment by third parties. Similar to HCFA 1500 but used for inpatient (retrieved from [http://www.mcres.com/mrdef.htm](http://www.mcres.com/mrdef.htm)).

Insurance companies all have their own fee schedule that determines how much each different service pays. Most companies also have different requirements about how soon claims need to be filed after the service. This is known as timely filing – if a provider files claims for services after the timely filing limit has passed, they will not get paid. Timely filing limits usually are anywhere between 90 days and 365 days.

There are different claim forms for inpatient and outpatient services. Electronic claims submission is now a requirement, which means that providers have to have some kind of mechanism for submitting their claims online. There are multiple clearinghouses that do this for providers, and there are also online programs that can help providers with both treatment
planning and claims. The first step for most providers is to get an NPI (National Provider ID) number, because this number is what is used for credentialing and for billing.

Once you have been paid for services, it is possible for money to be recouped if the provider cannot provide documentation of the services. Chart audits are routinely done by most insurance companies. It is important to check benefits, know timely filing limits, and respond quickly when there are claim problems.

The top 6 reasons Payers Reject or Delay Claims:

- The health plan did not get the claim
- CPT or diagnosis code is missing or incorrect
- Provider and/or patient info is incomplete
- Policy info is missing or incorrect
- The plan does not cover the service
- Administrative errors or delays by the payer

**Tips and Advice**

There are certain things that this writer has put together as helpful tips for providers that work with MCOs.

- Find ways to keep current on changes in requirements and processes, either through websites, email lists, or newsletters.

- There are some limitations on who you can see depending on what your license is. For example, clients with medicare can only see LICSW’s or Doctoral level licensed psychologists, LMFT’s or LPCC’s who see clients with Medicare will not be reimbursed by Medicare for the services.
If something does not make sense; either a form, a policy, or a denied claim, ASK QUESTIONS. It is helpful to have a specific contact at each company for different issues like claims, credentialing, and authorization, to have a place to start. If not satisfied with responses from certain companies, providers can always try to schedule a face to face meeting to discuss the problem. If that does not work, providers can escalate their issues to supervisors or managers, or even to DHS or the insurance commissioner.

MCOs can be helpful to you! They should be current on DHS guidelines. They have experienced clinicians. They can give helpful tips and advice about treatment options, help you find other sources to refer your clients to (psychiatry, chemical dependency authorizations, etc.), and they can refer clients to you.

The people who work at managed care organizations are humans and are often passionate about client care. Treat them with respect and find a way to work with them as opposed to against them.

Examples of Current MCO Requirements and Sample Forms

Start with DHS when trying to learn about different requirements. They generally have the most stringent requirements, and the DHS requirements generally need to be followed for any kind of state funded insurance product. They have specific requirements about psychotherapy including requirements for progress notes and charting.

For example, below are the requirements for what must be contained in a progress note and what must be contained in a treatment plan (retrieved from http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_058037);
Progress Notes

A progress note must be legible and is the documentation of treatment information which can be kept to a minimum.

Progress notes include:

• Type of service
• Date of service
• Session start and stop times
• Scope of service (nature of interventions or contacts including treatment modalities, phone contacts, etc.)
• Recipient’s progress (or lack of) to overall treatment plan goals and objectives
• Recipient’s response or reaction to treatment intervention(s)
• Formal or informal assessment of the recipient’s mental health status
• Name and title of person who gave the service
• Date documentation was made in the client record

Other elements that may be included:

• current risk factors the recipient may be experiencing
• emergency interventions
• consultations with or referrals to other professionals
• summary of effectiveness of treatment, prognosis, discharge planning, etc.
• test results and medications
• symptoms

For clinical trainees conducting psychotherapy, the clinical supervisor must review and approve recipient’s progress notes in accordance with the clinical trainee’s supervision plan.

While providers need to keep progress notes in order to document treatment, it is at the discretion of the provider whether to keep additional psychotherapy notes. A psychotherapy note
is the documentation or analysis of the contents of conversation during an individual, group or family psychotherapy session. Psychotherapy notes are kept separate from the rest of the individual’s medical record and are protected from normal record release under HIPAA even when requesting an authorization or continued services.

**Individual Treatment Plan (ITP)**

MHCP only covers services in accordance with the recipient’s ITP, except diagnostic assessments, and in cases of emergency. The recipient’s ITP must be:

- Based on the information and outcome of the diagnostic assessment
- Involve the recipient in the development, review and revision of the ITP
- Developed by the mental health professional who provides the psychotherapy, no later than the end of the first psychotherapy session, or five days, if the recipient is in an adult day treatment program
- Signed by the professional and recipient (including revisions), unless the request is not appropriate to the recipient’s mental health status. In the case of a child, the child’s parent, primary caregiver, or other authorized person must sign the ITP. If a recipient refuses to sign the ITP or his/her mental health status contraindicates the request, the mental health professional must document the circumstances in the ITP
- Reviewed at least once every 90 days and, if necessary, revised. Exception: ARMHS allows review at least once every 180 days and an individual community support plan (ICSP) to be used instead of an ITP if a mental health case manager is involved and with the recipient’s approval. The ICSP must include the criteria in MS 256B.0623, subd. 10, 2
Current Insurance Companies in MN – some of the major companies and how they can be contacted:

<table>
<thead>
<tr>
<th>Company</th>
<th>Contact Information</th>
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</thead>
<tbody>
<tr>
<td><strong>Blue Plus</strong></td>
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<tr>
<td>Network Management</td>
<td>PO Box 64179, St Paul MN 55164-9867</td>
</tr>
<tr>
<td>Provider Service Center</td>
<td>(651) 662-5200, 1-800-262-0820</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>PMAP/MinnesotaCare/MS+</td>
<td>1-800-711-9862, 1-888-740-6013</td>
</tr>
<tr>
<td>Dental – Delta Dental</td>
<td>(651) 406-5907, 1-800-774-9049</td>
</tr>
<tr>
<td>Pharmacy – Prime Therapeutics</td>
<td>1-800-821-4795</td>
</tr>
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| **HealthPartners**       |                                                          |
| PO Box 1309              | Minneapolis MN 55440-1309                               |
| Provider services/contracting | (952) 967-7998, 1-866-885-8880                           |
| Behavioral health        | (952) 883-7501                                           |
| Chiropractic – ChiroCare | 1-888-638-7719                                           |
| Pharmacy – Pharmacy Administration | 1-800-492-7259                     |

<p>| <strong>Hennepin Health</strong>      |                                                          |
| MHP                      | Grain Exchange Building                                  |
| 400 South Fourth St, Ste. 201 | Minneapolis, MN 55415                                    |
| Provider Help Desk/Contracting | 1-800-647-0550                                    |
| Medical/Behavioral Health| (612)466-9536 Fax                                       |
| Dental – Delta Dental    | (651)406-5907                                           |</p>
<table>
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<tr>
<th>Service Type</th>
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<tbody>
<tr>
<td>Pharmacy – Caremark</td>
<td>1-800-345-5413</td>
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<tr>
<td>Itasca Medical Care (IMCare)</td>
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<tr>
<td>Itasca Resource Center</td>
<td>1219 SE 2nd Avenue</td>
</tr>
<tr>
<td></td>
<td>Grand Rapids MN 55744-3983</td>
</tr>
<tr>
<td>Provider services/contracting</td>
<td>1-800-843-9536 x 2133</td>
</tr>
<tr>
<td></td>
<td>(218) 327-6133</td>
</tr>
<tr>
<td></td>
<td>(218) 327-5545 Fax</td>
</tr>
<tr>
<td>Pharmacy – Caremark</td>
<td>1-800-345-5413 Service Auth</td>
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<tr>
<td>Medica</td>
<td></td>
</tr>
<tr>
<td>PO Box 9310</td>
<td>Mail Route CP340</td>
</tr>
<tr>
<td></td>
<td>Minneapolis MN 55440-9310</td>
</tr>
<tr>
<td>Provider services/contracting</td>
<td>1-800-458-5512</td>
</tr>
<tr>
<td></td>
<td>(952) 992-8667 Fax</td>
</tr>
<tr>
<td>Medica Behavioral Health</td>
<td>1-800-848-8327</td>
</tr>
<tr>
<td>Chiropractic – OptumHealth Care Solutions, Physical Health</td>
<td>1-800-873-4575</td>
</tr>
<tr>
<td>Dental – Delta Dental</td>
<td>(651) 406-5919 1-800-459-8574</td>
</tr>
<tr>
<td>Pharmacy – MedImpact</td>
<td>1-800-788-2949</td>
</tr>
<tr>
<td>Metropolitan Health Plan (MHP)</td>
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</tr>
<tr>
<td>Grain Exchange Building</td>
<td>400 South Fourth St Ste 201</td>
</tr>
<tr>
<td></td>
<td>Minneapolis MN 55415</td>
</tr>
<tr>
<td>Provider Help Desk/contracting</td>
<td>1-888-562-8000</td>
</tr>
<tr>
<td></td>
<td>(612) 466-9536 Fax</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>1-888-562-8000</td>
</tr>
<tr>
<td></td>
<td>(1-888-734-0008 Fax (Service Auths))</td>
</tr>
<tr>
<td>Dental – Delta Dental</td>
<td>(651) 406-5907</td>
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<td>Service</td>
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<tr>
<td>Pharmacy - Caremark</td>
<td>1-800-774-9049</td>
</tr>
<tr>
<td></td>
<td>1-866-693-4620 Medicare Coverage</td>
</tr>
<tr>
<td></td>
<td>1-800-345-5413 Medicaid Coverage</td>
</tr>
<tr>
<td><strong>PrimeWest Health</strong></td>
<td></td>
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<tr>
<td>Pharmacy – Prime Therapeutics</td>
<td>1-800-821-4795 Provider Helpdesk</td>
</tr>
<tr>
<td></td>
<td>1-800-693-6651 Part D Formulary Exception Requests for PrimeWest Senior Health Complete (HMO SNP), Prime Health Complete (HMO SNP)</td>
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<tr>
<td></td>
<td>1-800-711-9866 Formulary Exception Requests for Prepaid Medical Assistance Program; Special Needs BasicCare, MinnesotaCare, and Minnesota Senior Care Plus</td>
</tr>
<tr>
<td><strong>South Country Health Alliance (SCHA)</strong></td>
<td></td>
</tr>
<tr>
<td>Provider help desk</td>
<td>1-800-995-4543</td>
</tr>
<tr>
<td>Provider contracting</td>
<td>(507) 444-7770 or 1-866-722-7770</td>
</tr>
<tr>
<td>Pharmacy – Prime Therapeutics</td>
<td>1-866-325-5233</td>
</tr>
<tr>
<td>Chiropractic – Clinical Resource Group</td>
<td>1-866-281-1997</td>
</tr>
<tr>
<td>Dental - DentaQuest</td>
<td>1-800—341-8478</td>
</tr>
<tr>
<td><strong>UCare</strong></td>
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</tr>
<tr>
<td>Provider Assistance Center</td>
<td></td>
</tr>
<tr>
<td>PO Box 52</td>
<td></td>
</tr>
<tr>
<td>Minneapolis MN 55440-0052</td>
<td></td>
</tr>
<tr>
<td>Clinical services, authorizations, intake</td>
<td>(612) 676-6705</td>
</tr>
<tr>
<td></td>
<td>1-877-447-4384</td>
</tr>
<tr>
<td>Provider assistance center</td>
<td>(612) 676-3300 1-888-531-1493</td>
</tr>
<tr>
<td>---------------------------</td>
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</tr>
<tr>
<td>Behavioral Health BHP</td>
<td>(763) 525-9919 Main 1-800-361-0491 Intake 1-800-645-6296 1-888-889-7822 Fax</td>
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<tr>
<td>MMSI</td>
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<tr>
<td>Chiropractic – ChiroCare</td>
<td>1-888-638-7719</td>
</tr>
<tr>
<td>Dental – DentaQuest Provider Services</td>
<td>1-800-341-8478</td>
</tr>
<tr>
<td>Pharmacy – Express Scripts, Inc (ESI)</td>
<td>1-877-558-7523 Phys auth 1-800-357-9577 Fax 1-800-824-0898 Gen info</td>
</tr>
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</tbody>
</table>

**UBH/MEDICA**


**MHP**

[http://hennepin.us/portal/site/HennepinUS/menuitem.b1ab75471750e40fa01dfb47ccf06498/?vgnextoid=8c3e403f28d74210VgnVCM10000049114689RCRD](http://hennepin.us/portal/site/HennepinUS/menuitem.b1ab75471750e40fa01dfb47ccf06498/?vgnextoid=8c3e403f28d74210VgnVCM10000049114689RCRD)

**BCBS**


**HP**


**BHP**

[www.bhpcare.com](http://www.bhpcare.com)

[www.ucare.org](http://www.ucare.org)
Other helpful websites and resources

DHS (Minnesota Department of Human Services)

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION
&RevisionSelectionMethod=LatestReleased&dDocName=Home_Page

CMS (center for Medicaid and Medicare)

http://www.cms.gov/

MDH (Minnesota Department of Health)

http://www.health.state.mn.us/divs/hpsc/mcs/index.htm

MN Laws and Statutes

https://www.revisor.mn.gov/rules/?id=9520.0760
https://www.revisor.mn.gov/rules/?id=4685
https://www.revisor.mn.gov/statutes/?id=62D

CredSmart: A website that allows providers to fill out and submit their application to multiple sources


APA: Resources from the American Psychological Association:

http://www.apapracticecentral.org/reimbursement/billing/index.aspx

Other resources providers should have

- county contact lists
- CPT and or HPCPS book
- transportation resources
- other resources (food, housing, legal)
Forms (samples included):

- Minnesota Uniform Credentialing Form and Provider Change form
- Minnesota Universal Treatment Plan form
- Sample forms created by this writer to give ideas about ways to organize:
  - MCO info form
  - session tracker form
  - claim/auth tracker form
  - other services form

Adlerian Considerations, Future Considerations, and Conclusion

Having learned all of this information about insurance companies and MCOs, how do the theories and practice of Alfred Adler fit in with them? There are several things to consider about Adler and MCOs. What would Adler have thought about MCOs and how does being an Adlerian therapist fit in with becoming credentialed with MCOs or getting authorizations? One of the main things outlined in this project is the importance of the relationship between MCOs and providers. As Adler was a proponent of healthy cooperation to foster social interest, I think he may have also been supportive of forming mutually cooperative and friendly relationships between providers and MCOs in order to foster mental health services. I think he would have appreciated the ideas of education and best practices in order to help the most people possible. Adlerian theory supports things such as holism and goal directed behavior, and those things are very much in line with many of the concepts of managed care.

If you are a practicing Adlerian therapist, how does this matter in terms of becoming part of provider networks and getting authorizations? I’m not sure that it does. Health plans will likely be less interested in the fact that you may call yourself ‘Adlerian’ and more interested in
how you actually treat different disorders and what your areas of specialization and expertise may be. If a review committee sees that you have done a ‘lifestyle analysis’ on a client, this will mean less to them then if you describe what a ‘lifestyle analysis’ is. Stating a lifestyle analysis was done says much less than stating that a comprehensive assessment of client’s background was done to help client understand mistaken thoughts and beliefs and understand patterns of unhealthy behavior. Being an Adlerian therapist is something to be proud of! However in terms of insurance authorization, it may be easier to describe what you are actually doing as opposed to just stating that you are doing Adlerian therapy. Adlerian therapy influences so many other schools of psychotherapy, that a description of Adlerian theory in action will have elements of CBT, psychoanalysis, behavioral therapy, rational-emotive therapy, etc. Most people who call themselves Adlerian therapists have had teachings and influences from many sources other than just Adler. The terminology of what is being done in therapy is less important than the actions and outcomes that happen in therapy, and so far in my experience at Adler graduate school, it seems to me that when Adlerian techniques are used, the outcomes will speak for themselves.

MCOs and insurance companies have been around for quite some time. Levels of oversight seem to ebb and flow, but in this writer’s experience the trend at this point is for increased oversight. Financial concerns and insurance costs are high which means that insurance companies are looking to find ways to save money. More and more Minnesotan’s are going on to state funded products because of the poor economy. It is in provider’s best interest to have an idea of how to work with MCOs and insurance companies. Hopefully this project will be helpful in helping providers work more efficiently and effectively with MCOs and insurance companies, and thus have more time to focus on treating their clients.
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