On My Mind: 'Why don't you take my insurance?

Buying good health insurance is an expensive proposition, and it seems only right that it should cover good mental health care. Yet a large portion of mental health practitioners do not deal directly with insurance companies. The fact is that working with insurance companies is an expensive, risky, and intrusive proposition for clinicians, and it changes the relationship between clinician and patient. It generally means lower payments for services, frequently means disruptive interference in patient treatments, and inevitably means a huge amount of time spent on paperwork, phone calls, and bureaucracy.

Hospitals and some clinics hire staff to handle the insurance company burden. But for many in individual private practice, where the clinician is her or his own support staff, dealing with insurance companies is a nightmare — frustrating, insanely time-consuming, devaluing, and uneconomical. A wonderful psychotherapist who recently moved to the Vineyard wanted to build her practice and perform a community service, and so she signed up with a number of public

and private insurance plans. That in itself took hours of paperwork and phone calls. Then she learned that the payments for her work were distressingly low and that the ongoing paperwork would take hours more of her time. Now she wonders whether she made the right choice.

There is a wonderful NPR piece on mental health coverage that describes similar challenges: bit.ly/nprmenthealth.

Social worker Jennifer Vogel, LICSW, is the program director at Island Counseling Center (ICC). She tells a story of working for three and a half hours to get medication coverage for a single client. While the insurance companies almost never turn down her appeals, the hoops she has to go through to obtain approvals are seemingly endless. “And,” she told me, “which medications they approve can change without notice. So suddenly a patient can’t get their medication, and I have to start the process all over again.” As for getting approval for psychotherapy, she reported, “I can spend hours advocating to get more treatment. I might call the insurance company three times and get three different stories. One person will tell me that the client can only have 20 sessions per year, no matter how severe the problem. Another will tell me that no authorization is required, and a third will tell me that I can get more sessions approved if I fill out additional paperwork several times each year.” In addition to Ms. Vogel, ICC has a full-time person whose job it is to deal with insurance companies. “The reimbursement rate is generally less than the cost of providing the service. We need to make up the balance with fundraising.”

“Navigating the restrictions has changed the landscape of treatment. We have to accommodate each insurance company, the Department of Public Health, and the Department of Mental Health. Documentation requirements have become such a big part of therapy that therapy is cut short by the need to document answers to the required questions to justify the billing code.” Then there are “clawbacks” — retroactive denials by insurance companies of previously approved reimbursements. See bit.ly/commagclawbacks.

Insurance companies have the right to ask to see clinician’s chart notes on patients from any time in the past. If the notes do not follow the format mandated by the insurance company, the insurance company can ask for all payments to be returned. Several Island therapists have been asked to return many thousands of dollars. One therapist, who spoke on the condition of anonymity, told me that she used to think that she and the nonprofit insurance company were “on the same team, working together for the better mental health of our clients.” But then notes

were requested. The therapist had made a single mistake: She had failed to "time-stamp the note." The insurer then requested a total of 80 notes, and since none were time-stamped, all payments for those visits ($5,000 in total) needed to be returned. Apparently, insurance companies' mission to make a profit sometimes comes at the expense of the clinician. This therapist has decided to stop making appointments for new people who have public insurance plans. Preparing appeals (that have so far been unsuccessful) involves deadlines and stress. After working on appeals, she often finds it hard to be on top of her game the next day.

Another Island therapist told me that she has been asked to return almost $6,000. She did time-stamp the notes, but she didn't sign them. She is not opting out, because she believes that that would be giving in to the insurance company's plan, and she wants to remain available to people with limited resources. Nonetheless, she feels devalued, exploited, and furious.

One thing that can help with documentation is using an electronic medical record (EMR). The EMR time-stamps, signs, and codes the visit. But it also prompts questions that may be necessary for billing that are not always relevant, and hence disruptive to the relationship and natural flow between patient and clinician, especially when the clinician fills in information on the EMR during their meetings. The alternative is spending unpaid time after the session to fill out the forms. The insurance industry values the EMR highly. Doctors who do not use the EMR at least 50 percent of the the time are now docked 3 percent by Medicare.

According to John McDermott, Vineyard visitor and co-founder of a recently sold EMR company, "Much of what is included in the EMR is unneeded and unuseful to patients and clinicians. It is largely written by coders to benefit the specifications of the insurance companies or hospital network. The driver is bill collection, rather than patient service. Each insurance company has its own formularies of approved medication, its own limits, and its own copays. It is hard to find out what these formularies, copays, and limits are. Different insurance companies require different information from the EMR.

"The clinician needs to follow the EMR protocol rather than their own. It basically turns the clinician into an unpaid employee of the insurance company."

After 20 years in private practice, Julia Kidd, LICSW, recently severed her last enrollment with an insurance company. "It was not an easy decision," she told me. "I consider myself a healer, in a helping profession, and I believe care should be affordable and accessible. But over time I recognized that maintaining a

relationship with insurance companies was not healthy for me. Letting go of insurance was like letting go of an abusive relationship.

"There was, of course, the financial aspect; the payment is low, and they would randomly reduce the rate. One company reduced session time from 50 minutes to 45, then further reduced the reimbursement. There are countless unpaid hours submitting claims, justifying treatment on behalf of clients, and writing reports. There is no compensation for experience or training. They don't seem to value what we do as clinicians.

"But even more importantly," she continued, "working with insurance means working and justifying treatment via a medical model, from the perspective of illness. By justifying my work in this way, I felt my personal integrity was out. I see clients from a wellness perspective, and look for health, strength, and resiliency. I look for what is working, rather than what is wrong. That just isn't what insurance companies want to hear."

It should be noted that even though some therapists do not accept insurance, they still do the paperwork for their patients to submit for reimbursement.

Personally, I am fortunate to be able to work in a combination of settings. The different ways in which I am paid and rewarded have a significant influence on my relationships with my patients. For work at the hospital and Windemere, I hire a billing agent who bills the insurance companies. I don't pay any attention to what I am paid, for two reasons: First, I have minimal control over what I am paid. The insurance companies determine that. And second, I glean far greater rewards than money from being part of a medical team, helping out with interesting medical and neuropsychiatric challenges, and feeling that I am making a unique contribution to our community. Nonetheless, in settings like Windemere, doctors are not paid well — or at all — for spending time thinking about patients holistically, doing psychotherapy, or coordinating care with family or other team members.

At MV Community Services/ICC, psychiatrists are paid less than in private practice. But the nonmonetary rewards are huge. There is a wonderful sense of teamwork and a lot of mutual appreciation. It is deeply gratifying to help people who would not otherwise be seen. Often people with the most severe mental illnesses are the people who can least afford treatment, and at ICC there is a staff to help them obtain insurance coverage. As a clinician, it is comforting not to worry about whether patients will be able to afford treatment. If there is a crisis, there is an entire treatment team ready to respond. And there is a staff that takes

care of all of the administrative issues, such as making appointments and dealing with insurance companies. If there is a struggle with an insurance company about paying for a medication, there is staff support.

Still, there is a downside to institutional settings. At ICC, the hospital, or Windemere, the client to a large extent is the insurance company. In private practice the client is entirely the patient. Absent the restrictions imposed by insurance companies, there is more of an opportunity to practice the art of medicine, and physician/patient relationships can feel deeper. Psychotherapy is an option. Being let into another person’s life in such an intimate way is an enormous privilege, minimizes the need for medication, and can often help in ways that medication alone cannot. In private offices, there is an added sense of privacy, and to a larger extent what is documented in chart notes is determined by clinical relevance, rather than the demands of the insurance company. In institutions, the doctor often makes less eye contact with patients, because he or she is busy typing into an electronic medical record. And it takes longer to accomplish the same amount of work, because of the need fill out the forms.

Most healthcare professionals go into our professions in large part because we cherish the relationships with our patients and the opportunity to help others. Insurance companies, regulating agencies, and the electronic medical record often feel devaluing, intrusive, and ultimately undermining of excellent healthcare.

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