USING INSURANCE TO PAY FOR COUNSELING: What it means, what it may mean

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In order to use insurance, a client must meet the criteria for a psychiatric diagnosis. When the client no longer meets the criteria, insurance can no longer be used.

The psychiatric diagnosis becomes part of the client's permanent medical record. Organizations that have access to the medical records have access to the psychiatric diagnoses. While mental health counselors have strict rules about sharing client information, insurance companies can share information with organizations that they do business with. That might include other insurance companies, pharmaceutical companies, and, with the new health care laws, the federal government. If insurance companies share information, they do not have to notify you and I believe they won't. So you will never know if your information has been shared or not or with whom.

On a personal note, this lack of control can be fertile ground for suspicion. My adult daughter has long moved out, but I sometimes get mail for her. I recently received a letter asking her if she would like to be part of a drug study for depression. How did they get her name? In the last year and a half my daughter has had two upsetting health issues; was her name chosen because of her recent medical history?

Medical care, insurance coverage and government regulations are changing. We can expect changes in the delivery and billing of counseling services. For example, the state of Oregon is seeking a waiver from current Medicaid rules to develop its own health management regulations. Part of the proposal is the development of Coordinated Care Organizations (CCOs). The CCOs will coordinate care between medical care and allied health professionals. No CCOs exist; it has not yet been determined what will qualify as coordinated systems. In addition to overseeing the mental health referral process, the CCOs will have to document services as will Accountable Care Organizations (ACOs), relatively large organizations such a hospitals and some medical care systems that have internal mental health services.

While information sharing requirements for mental health for coordinated care have not been defined, they will probably include basic information such as the date a referral was made, the date the client was seen, the client's diagnosis, documentation that a treatment plan was developed, and change measures to document progress or change.

If a client is using Medicare or the Oregon Health Plan, the changes will be incorporated into medical and counseling care when the state regulations are better defined. Private insurance policies written for state employees will likely be required to follow this model of care coordination and integration. It is expectable that insurance companies will use this model eventually for all their covered lives in order to avoid two separate administrative systems. If the model continues to be developed, it may be the standard of care integration within this decade.

WILL EVERYONE HAVE TO PARTICIPATE IN THESE PROCESSES?

People who pay out of pocket will not be part of the insurance system. Many mental health clinicians have sliding scales and discounts for out of pocket payments, in order to make private pay more possible. But private pay will not be possible or desired by some clients. For individuals using insurance, understanding the treatment and diagnostic issues will be important in making their decisions.

THESE SYSTEMS ARE FOR CARE COORDINATION AND BILLING; WILL THEY INFLUENCE COUNSELING DECISIONS?

Psychologists, counselors, social workers, psychiatric nurse practitioners chose their professions because they are interested in people and the human condition, because they believe everyone sometimes needs to talk about their life situations and their inner lives with someone who is not a friend or family member. Because mental health professionals want to be part of this process, they have pursued extensive training to become knowledgeable and helpful. None of these factors changes with bureaucratic changes. The goals and motives of the counselors remain the same.

Bureaucratic management of care emphasizes measuring and monitoring diagnostic symptoms and requires therapists to justify treatment and document progress. Insurance billing systems put the counselor between the client and the insurance company or state organization. This is already true to some degree. For example, some insurance companies routinely notify therapists on their panels of the average number of sessions they spend with clients and indicate whether this number is greater than the average among other therapists on the panel. The insurance company is attempting to encourage efficiency. The therapists experience this as pressure to offer briefer therapy. Insurance companies can and sometimes do ask for client session notes. They do not do this often but it does happen; clients are not notified and cannot deny the request. The insurance companies can review the notes and decide that treatment is not necessary or was not necessary; if they conclude that past therapy was not necessary or was not appropriate, they can demand that all insurance payments be refunded to the insurance company. This does not happen often; but it has happened. Clients have effectively lost privacy and therapists must be aware of the insurance companies' right of review when counseling and writing notes.

Bureaucracies tend to focus on standardization, e.g., standard diagnostic criterion, standard treatment plans, standard outcome measures. Clinicians learn these systems and can use the terminology, but they were drawn to the field because of their recognition that each person is different, and working with each individual is unique. Clients, well, does anyone experience themselves and their concerns as standard?

Most mental health practitioners have fundamentally different views of human suffering, personal growth and the nature of counseling than regulators or insurance company bureaucrats. Communication, or the appearance of communication, is possible because of psychiatric terminology and because of research on effective therapies. One must ask what happens to therapy when the people determining whether therapy is necessary, appropriate or effective (clerks in insurance companies or in ACOs) are not mental health therapists and when therapists must justify their work to these clerical workers?

One consequence of this division is that psychiatric diagnoses become very important. Understanding the nature of psychiatric diagnoses is complex, but in brief most psychiatric diagnoses are clusters of symptoms rather than discrete disease entities such as measles or diabetes. Some symptoms are generally recognized as serious, e.g., hallucinations, others may be serious but are more subjective, may mean different things to different people and can be transitory, e.g., feelings of hopelessness.

When psychiatric diagnoses are the justification for treatment and a yardstick for evaluating improvement, the presence or absence of symptoms becomes important. Clients, while recognizing the emotional symptoms, may really be more focused on other issues, e.g., problems with bosses, decisions about a marriage, low self-esteem, self-doubt, recurring anger, lack of self-understanding, frequent unhappiness or dissatisfaction with life, etc.. The institutional focus on symptoms forces the therapist to focus on symptoms. Could therapists unwittingly treat for symptom decline just as teachers may teach for the test, if that is the metric of their competence? Frankly, I think it would be naïve to think that therapists will not be inadvertently influenced and may subtly redirect therapy. It should be noted that other metrics exist to evaluate therapy that do not focus on symptoms, that allow the client to evaluate effectiveness in a quantifiable way, and that research has shown to correlate with effective therapy. (See CDOI information and discussions at http://heartandsoulofchange.com/) Intelligent systems would do well to focus on these other measures, but there is currently no discussion of this.

I sometimes ask clinicians if they think insurance billing affects counseling. Opinions vary. One senior clinician felt unaffected by insurance, but noted having a gift for "client protective bull shit in writing treatment reports." Another senior clinician acknowledged treating insurance clients completely differently than private pay clients.

In summary, symptom-based diagnoses and the use of insurance may have more effect on therapy than one might ideally want.