

pediatric mental health payment strategies targeting payers

*strategies for system change in children's
mental health: a chapter action kit*

Carriers may have health plans that do not cover mental health services or that “carve out” mental health benefits completely or partially (eg, Following are strategies for pediatric practices to use in promoting coverage and payment of mental health care as well as managing carrier denials and contractual issues related to pediatric mental health. Should a practice have several health plan contracts, these strategies may be concentrated on the top (3-5) major plans with which the practice works.

Health insurance carriers have multiple health plans and coverage may vary from plan to plan. Some plans may include mental health parity in which the benefits for mental health are on par with the health plan. The key is to determine the level of coverage by the health plan for pediatric mental health services.

Dealing With Mental Health Carve-outs

Some carriers may carve out mental health services from the medical provider network, assigning them to a smaller mental health specialty network or a disease management program. Employers or families may select a health plan that has limited mental health benefits.

- The pediatric practice should contact the carrier to determine the nature of the carve- out and the degree to which coverage and payment are available for mental health services.
- Pediatricians and their staff should be aware of health plan enrollment periods and be available to advise their patients’ families on coverage issues. Often, families make decisions on health plan selection on the basis of premium expense, without consideration of other out-of-pocket expenses, such as deductibles, co-payments, and level of coverage.
- Advocate for coverage and payment of pediatric mental health services, particularly during the contract renewal period.
- Frame your position on how lack of coverage impacts quality of care, cost effectiveness, and patient satisfaction. Carriers are very conscious of quality issues, expenses and efficiency, and their market share.
- Provide reassurance that increasing access to outpatient mental health services creates cost savings in areas such as emergency room utilization and hospitalization. Studies have shown that per member/per month mental health costs do not increase significantly when mental health benefits are at parity with medical benefits.
- Highlight cases in which your practice has provided high-quality, cost-effective mental health services.

Joining the Network

While most behavioral health plans are limited to mental health specialists, there is a movement by health plans to merge mental health and medical benefits and to expand their network. Developmental-behavioral pediatricians, in particular, may want to participate as mental health professionals.

- Check with the carrier to determine whether the provider panel is open to pediatricians and what credentialing criteria may be in place.
- See whether the carrier provides training or online programs that enable prospective providers to join the network.
- Determine whether access to mental health specialty care is an issue for the carrier, and use this to negotiate with the carrier to serve as a mental health professional. Carriers may realize that pediatricians may play a role in mental health care screening, evaluation, treatment, and/or follow-up.

Payment for Non-covered Services

If mental health benefits are not part of the health plan, or if the pediatrician is not part of the network, the family would be financially responsible for mental health services. The clinician should obtain a waiver or advance beneficiary notice prior to providing non-covered services. A waiver is a statement that a patient/parent/guardian signs acknowledging that the requested service is, or may not be, covered by health insurance and accepting responsibility for payment for the service. The waiver may be accompanied by a request for payment for the service at the time of the service. Clinicians should seek the advice of legal counsel before incorporating the use of waivers into their practice, as the use of waivers may not be permitted by the terms of contract(s) with the third-party payer or state law.

Managing Denials and Appeals

When facing denials by carriers, strategies include filing appeals and negotiating contractual provisions. A sample letter to send to carriers on bundling and carve-outs is included.

Filing Appeals

Pediatric practices can follow these general guidelines when appealing claim denials or partially paid claims):

1. Review all carrier explanation of benefits (EOB). Compare the billed amount and *Current Procedural Terminology (CPT)* codes with the EOB to determine the level of discounts, denials, inappropriate carrier re-coding, or partial payments.
2. Make sure that the claim was prepared properly, that all information is correct, and that documentation supports the *CPT* codes. Once assured that the denial was not due to an error on the practice's part, proceed with the appeal.
3. Send appeal in writing and to the appropriate person with decision making authority—look up the contact person in the contract or call the carrier, explain the situation and what is coming so they can be on the lookout. If you are not satisfied with the response, contact the plan's medical director.
4. Send the appeal by certified mail to verify receipt by the health plan.

5. List the member's name, carrier identification number, and claim number on all documentation.
6. State your case in objective and factual terms. Identify the result you want and provide medical justification and *CPT* coding guidelines to support your case (keep in mind most claim processors do not have a medical or coding background, so be clear and specific). Appeal letters that can be used as templates are available on the My AAP site, private payer advocacy page at <http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Pages/Private-Payer-Advocacy-Templates-for-Appeal-Letters.aspx>.
7. Develop a plan on how denials can be avoided in the future, particularly if it is a recurring problem. Be sure to point out to the carrier that inappropriate carrier claims denials are an unnecessary expense to both the carrier as well as the practice.
8. Monitor for a response. If the carrier does not respond within the time frame specified in your initial appeal, follow up with a second letter.
9. Create a spreadsheet to track appeals to each carrier so that, at contract renewal time, you can determine whether to continue to work with that carrier and identify items to modify in the contract.
10. Each health plan should have a written statement explaining the procedures required for both first and second level appeals. If it is not excluded in the contract, and the practice has correctly coded and properly documented the services, continue to appeal. Should further action be required, contact the state department of insurance or depending on the state in which you practice, the state department of banking and insurance or state department of health. Most states have prompt pay laws. If a managed care organization violates the prompt pay law, the physician may be eligible for interest payments on the amount owed, depending on state law.
11. If a claim is denied and the health plan informs the practice that the service is not covered or is the plan member's responsibility, bill the plan member and include a copy of the EOB and denial with the bill.
12. Contact your AAP chapter to keep it aware of your issues. Several chapters have pediatric councils that meet regularly with health plan medical directors and Medicaid representatives to address coverage issues. Utilize the AAP Hassle Factor Form to report problems with carriers. (Some chapters have made the Hassle Factor Form available on their Web site, or it can be accessed on the MyAAP site under private payer advocacy at: <http://www.aap.org/en-us/professional-resources/practice-support/financing-and-payment/Pages/Hassle-Factor-Form-Concerns-with-Payers.aspx>.)

Negotiating Contractual Provisions

In contacts with the health plans to discuss contractual issues, the key components are to:

1. Address the issue of benefit coverage with the person who has authority to make decisions regarding payment. The carrier provider representative may not have the decision-making authority in this type of matter.
2. Focus the argument on how this is cost-effective to the family and health plan, as well as how it relates to quality care. (Provide documentation supporting your position.)
3. Frame your position around the impact on quality of care, cost-effectiveness, and

patient satisfaction. Carriers are very conscious of quality issues, how a proposed change will affect overall expenses and efficiency, and their market share. The carrier's current policy may not cover mental health-related services, and the carrier needs to be made aware of the impact to the patient, family, pediatrician, and carrier.

4. Consider notifying the family and employer, since they may bring pressure onto the carrier and employer to expand health plan coverage.
5. If a carrier refuses to cover medical providers for services related to mental health, the practice then needs to decide whether to provide the service or refer the family to the plan's network mental health professional for those services and inform the family that it is the family's insurance carrier requirement. The family and/or employer, as the purchaser, then may bring pressure onto the health plan to expand coverage.