Appealing the Denial of Mental Health Care

By Eric M. Plakun, MD, Associate Medical Director and Director of Biopsychosocial Advocacy

Many people have had the unhappy experience of being denied insurance coverage for mental health treatment they, their family, and doctor agree is medically necessary. Appealing denials can be complicated, frustrating, confusing, and difficult to navigate.

If you receive a denial from your insurance company for mental health treatment that you and your treating clinician believe is medically necessary, there are three important tools to maximize the chances for success in an appeal:

1. Use the patient’s voice as a party to a binding contract

   The contract generally supports access to medically necessary care, meeting generally accepted standards. Insist on access to the written criteria used to determine medical necessity for the treatment you are seeking and to which ones they say your case doesn’t meet.

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   Use the patient’s voice as a party to a legally binding contract to provide care

   The contract generally supports access to medically necessary care, meeting generally accepted standards. Insist on access to the written criteria used to determine medical necessity for the

   your insurance company or the reviewing agency—including hold times, referrals to other phone numbers, and the like. Show that you have the will and the wherewithal to stand up for your rights.

   Anchor appeals to third-party resources

   Research and other benchmarks to back up claims of medical necessity are helpful in the appeals process. There are instruments to guide level-of-care decisions (like access to residential or intensive outpatient programs) using objective methodology, such as the Level of Care Utilization System (LOCUS) developed by the American Association of Community Psychiatrists and used in 26 states and in multiple countries (and available online at: providersearch.mhnet.com/Portals/0/LOCUS.pdf). In addition, the American Psychiatric Association (APA) Clinical Practice Guidelines often lay out evidence-based components of treatment for many disorders. The LOCUS and the APA Clinical Practice Guidelines can provide an objective frame of reference—in fact, many insurance companies and reviewing agencies claim to use both in developing their own criteria.

   Current peer-reviewed research can also anchor appeals to an evidence base for specific kinds of treatment. As you’ll read on page 2 in this newsletter, Riggs has organized a large body of research supporting the kind of longer-

   continued on page 4
It is my pleasure to share with you the Winter 2017-18 issue of the ARC News, and to offer my sincere best wishes for the holiday season.

In this issue, and building upon our successful Fall Conference, Mental Health Parity, Ethics, and the Law, Dr. Eric Plakun, associate medical director and director of biopsychosocial advocacy, shares with us a toolkit for maximizing the likelihood of gaining insurance support for medically necessary psychotherapy and other psychosocial treatments. Dr. Jane Tillman, the Evelyn Stefansson Nef Director of the Erikson Institute, offers an important perspective on the opioid crisis, part of a four-part series on our blog that I encourage you to read at: www.austenriggs.org/blog-post/something-for-the-pain. Finally, you will find a short article about a new and important section of our website—“Does Our Treatment Work?” (www.austenriggs.org/does-our-treatment-work)—that summarizes available evidence for the effectiveness of our treatment approach.

Thank you as always for your support of and interest in our work.

Best,

Andrew J. Gerber, MD, PhD

From the Medical Director/CEO

Does Our Treatment Work?

By Steven Ackerman, PhD, Accreditation Manager, Manager of Clinical and Organizational Evaluation, Team Leader, and Staff Psychologist

A CONSISTENT AND EXPlicit PSYCHODYNAMIC FRAMEWORK guides the Austen Riggs Center’s treatment approach. We integrate a range of interventions, including individual psychotherapy, psychopharmacology, family work, case management, nursing care, and a therapeutic milieu with groups and activities, into a structured treatment approach that offers enough built-in flexibility to meet varying needs while encouraging individual choice and self-expression. In addition, this framework allows patients to bring their troubled ways of relating, seeing, and interpreting the world to light in order to promote understanding, stimulate development, and encourage more adaptive ways of relating. Though this kind of holistic, integrative approach is widely viewed as clinically helpful—and even essential—when treating complex psychiatric patients, most research necessarily focuses more narrowly on separate techniques and modalities. However, there is ample relevant evidence for the efficacy of aspects of our treatment.

There is extensive scientific evidence, collected over several decades, that psychodynamic psychotherapy is an effective and clinically useful approach for treating many complex psychiatric problems, including severe character disorders, trauma, borderline personality disorder, anxiety, and depression (Leichsenring et al. 2015). Grounded in this empirical base, psychodynamic psychotherapy is a standard part of contemporary psychiatric practice (Oldham 2005). Standard practice guidelines issued by professional organizations such as the American Psychiatric Association (APA) include psychodynamic psychotherapy among other evidence-based treatment options (APA Practice Guidelines).

Evidence supports the effectiveness of psychodynamic treatment alongside other, shorter treatment approaches such as Cognitive Behavioral Therapy (CBT). Although CBT is an effective therapy and works for certain psychiatric conditions, it is not the only therapy with clinical and empirical support. Experienced, well-trained therapists have been found to use both CBT and psychodynamic techniques in their clinical work with patients (Blagys and Hilsenroth 2000); (Hilsenroth et al. 2005). In addition, there is a large body of current research evidence that demonstrates little to no difference in effectiveness between CBT and other common forms of treatment, including psychodynamic therapy (Clarkin et al. 2007); (Leichsenring et al. 2015); (Thoma et al. 2012); (Luyten, Blatt, and Fonagy 2013). In fact, most studies that have compared CBT and psychodynamic therapy with either no treatment conditions or treatment-as-usual conditions have found both CBT and psychodynamic therapy to be equally effective (Cooper et al. 2003); (Driessen et al. 2013); (Leichsenring, Klein, and Salzer 2014); (Levy et al. 2006).

Research has also shown that longer duration of treatment is correlated with a reduction in symptoms (Bateman and Fonagy 2008). Longer-term psychodynamic treatments have been shown to lead to greater relief and more sustained change compared to shorter-term treatments (deMaat et al. 2009); (Leichsenring and Rabung 2008); (Leichsenring and Rabung 2011); (Leichsenring et al. 2015).

In an effort to compile and organize the information related to the efficacy of our treatment approach, we have added a new section to our website titled “Does Our Treatment Work?” (www.austenriggs.org/does-our-treatment-work). Here you will find answers to questions about efficacy, links to relevant research, and a comprehensive reference list.
SUICIDE AND OPIOID USE/ADDICTION HAVE SOMETHING IN COMMON: they are attempts to solve the problem of pain, both physical pain and psychological pain (also known as “psychache”) (Shneidman 1998). Last summer the Centers for Disease Control (CDC) released a report indicating that death by suicide in the US increased by 24% between 1999 and 2014, translating to 44,193 lives lost each year to suicide—a rate of 13.26 per 100,000 individuals. And this year, in 2017, we have learned that deaths from drug overdoses have increased 2.5 times the rate in 1999, to a rate of 16.3 per 100,000 individuals (Hedegaard, Warner, and Miniño 2017). Of the drug overdose deaths in 2015, 25% involved heroin—triple the percentage of heroin overdoses in 2010. While there is a declining mortality among most diseases in the US, deaths from suicide and drug overdose have dramatically increased since 1999. Pain of one sort or another is often at the root of both suicide and addiction.

How might we think about the many causes of pain and the treatments for deadly symptoms that emerge in relation to pain? There are a host of environmental, epidemiological, social, and cultural factors that have been studied in relation to both phenomena, and yet understanding the mind of the individual who dies by suicide or drug overdose requires careful attention to how they subjectively experience and manage physical and psychological pain. The problem in the US for both suicide and opioid addiction is so severe that public health interventions are needed to dramatically decrease the death rate. Studies support the effectiveness of public health interventions that go beyond treating the individual’s symptoms and aim to intervene through environmental and social engineering, treating the larger contexts in which these problems are embedded (Barber, Hemenway, and Miller 2016); (David-Ferdon et al. 2016).

For suicide, one avenue of change is to restrict access to lethal means. In the United States, more than 50% of suicide deaths occur through the use of a firearm, and research supports the idea that sensible gun laws restricting access to lethal means would reduce the rate of suicide (Anestis and Houtsma 2017). For those who do own guns, increased “lethal means counseling” around suicide and firearm safety may also reduce the risk of suicide (Barber, Hemenway, and Miller 2016). Similarly, with opioid use/addiction, the overprescription of opioid medication for the past 15 years has contributed to the problem of opioid addiction in the US. As Jennifer Michaels, MD, and Eric Plakun, MD, have written about on the Riggs Blog (www.austenriggs.org/blog), this situation has occurred because physicians were worried about undertreating pain, pharmaceutical companies vigorously marketed opioid medication to consumers and physicians, and prescribing medicine for pain in the short-term can appear easier than understanding the causes and full symptoms of a pain disorder.

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REFERENCES


Congratulations to the Winners of the Austen Riggs Center 2017 Prize for Excellence in Mental Health Media

The Austen Riggs Center was pleased to award the 2017 Prize for Excellence in Mental Health Media to The Boston Globe Spotlight Team, comprised of reporters Maria Cramer, Scott Helman, Michael Rezendes, Jenna Russell, and Todd Wallack, and editors Scott Allen and Anica Butler, for their story “The San Antonio Way: How one Texas city took on mental health as a community—and became a national model,” part of the series, “The Desperate and the Dead.”

A call for entries for the 2018 prize will be announced in January 2018. Visit www.austenriggs.org/mediaprize for additional information.

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term, residential treatment we offer. Citing resources like these can help in building a case for treatment that you and your treating clinician believe to be medically necessary.

Invoke the parity law
The Mental Health Parity and Addiction Equity Act (MHPAEA) requires that the quantitative (e.g., number of office visits, or inpatient days, etc.) and non-quantitative (e.g., hurdles like prior authorization or concurrent review) limits applied to access to mental health care be comparable to those applied to medical coverage.

For example, if a health insurance company says someone with a mental health issue cannot receive treatment unless he stops drinking, but continues to cover treatment for someone with diabetes who is not following his diet, the policy is likely out of compliance with the parity law. Similarly, if an “intermediate” level of care like residential treatment is excluded except for those meeting criteria for acute inpatient treatment, but intermediate levels of care are covered, for example, for stroke patients who no longer need inpatient treatment, but need an intermediate level of care to regain the capacity to walk, talk, and do self-care, the policy is likely out of compliance with the parity law.

If you believe a denial does not comply with the parity law, raise this concern in the appeal. You may wish to speak with an attorney familiar with parity law violations or your State Attorney General’s Office.

While the tools outlined in this article do not address the larger issue of full implementation of the mental health parity law (it may take class action lawsuits to do this), I hope they are helpful for individuals appealing insurance denials for care that they and their treating clinicians believe to be medically necessary. Remember, even though the process is daunting, don’t give up, the right tools, support, and persistence can make a difference.