

Ohio Behavioral Health Provider Experiences with Insurance

Claims, Credentialing & Communication

Summer, 2021



Behavioral Health Providers
for Insurance Advocacy

Overview:

This report is a follow up to supplement our [first report in 2020](#) and includes qualitative and quantitative data from 66 respondents representing five disciplines within the behavioral health workforce: psychiatry, psychology, social work, professional counseling, and chemical dependency counseling. The survey explores general trends that we hope to assess over time and a deeper look at our memberships' experiences in claims processing.

The responses to this survey are summarized in three themes: 1) A small portion of claims require remedy but take up disproportionate time; 2) Administrative burden may be driving more providers to stop accepting insurance; 3) Claims denials have an outsized influence on clinical practice and can disrupt care. The themes illustrate that providers are struggling to provide accessible, high-quality services with such a high administrative burden and that many are choosing to stop taking insurance at all.

The following recommendations are offered to begin reducing this administrative burden.

Guidance and transparency on medical necessity

Our coalition would like every third-party payment company to provide a definition of medical necessity that is accessible to all paneled providers and consumers. Supplemental guidance providing evidence and reasoning for denial based on session-length, diagnosis, medication or intervention would support providers in maintaining high quality standards and reduce administrative burden.

Innovation in claims remedying systems

Our coalition welcomes any and all innovation that reduces the time and effort required to remedy errors and move claims along. An ideal system would allow for true continuity between communication so that providers do not have to repeat information and would include email and phone communication options.

Increased use of centralized credentialing resources

While this survey focused on claims, credentialing is a constant topic amongst our members. Centralization systems like CAQH feel redundant when providers are having to repeat this information with each individual company.

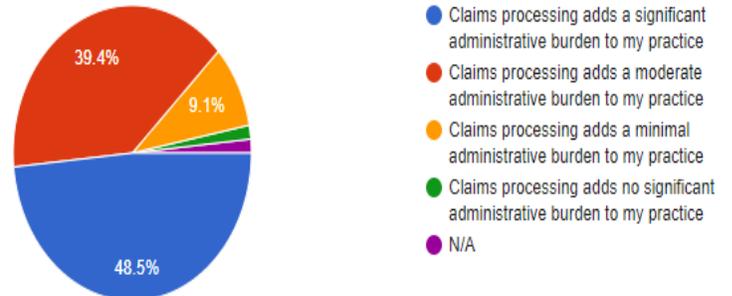
Survey Summary

1) A small portion of claims require remedy but take up disproportionate time

A strikingly high number (87.9%) of respondents indicated that claims processing adds a moderate or significant administrative burden to their practice. Respondents generally shared that filing initial claims is simple and not burdensome but that the follow up required to remedy a small portion of those claims requires inordinate time and labor. Lack of medical necessity as one broad category of claim denial is explored later in this report, but respondents also shared that even simpler issues like missing information and filing errors, regardless of fault, take significant time to remedy. Innovations are needed both on the front end to minimize chances of error, and throughout the claims-remedying process to improve communication and efficiency.

Regarding processing of claims, which statement is most accurate for your practice? (ex. delays, denials, take-backs)

66 responses



"[...] The variety of reasons for not processing the claims is astounding, requiring a laborious re-filing NOT related to an error at my end but because they process claims differently between divisions or plans. It seems to me to be a delay tactic. It adds to my investment of time and reduces further what I make for seeing the patient to begin with." – Counselor

"Submitting the claims is just a click of a key. Following up, trying to get questions answered regarding problem claims takes significant time. A lot of on hold or being transferred to another specialist." – Counselor

"My biggest complaint is the massive hurdles I must get over to get a problematic claim addressed. Usually, claims are processed correctly and without a problem. However, when a problem arises, it takes a great deal of time and effort to make actual contact (with a live person) in order to get it resolved." - Psychology

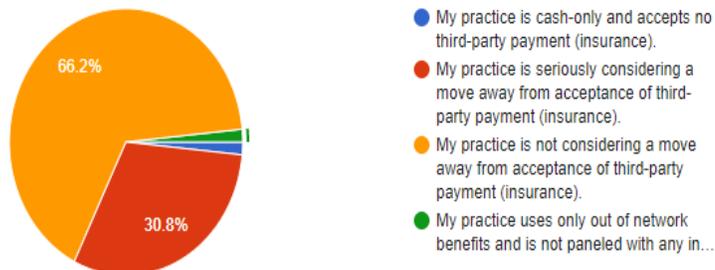
"It is so difficult to keep up with reimbursement when insurances do not send EOBs and ERAs to a central location. I have to check different websites, my EHR and my bank account in some cases to make sure I'm being paid. That's 3 different sites for just one reimbursement. So time consuming and frustrating." – Social Worker

2) Administrative burden may be driving more providers to stop accepting insurance

Behavioral healthcare appears to have an administrative burden that is unworkably high. 30.8% of respondents indicated that their practice is seriously considering a move away from acceptance of insurance, which is an increase from the last survey from this coalition when 24.3% indicated the same. Fewer practitioners accepting

Regarding third-party payers (insurance), which statement is most accurate for your practice?

65 responses



insurance will only widen access gaps that are already growing from related issues in recruitment and retention of behavioral healthcare workers. Providers have expressed a sincere wish to keep their services accessible and affordable by accepting insurance but are struggling with the practical reality of doing so.

"I keep being paneled with insurance in order to make counseling available to those who purchase insurance through the ACA exchange, and to see 2 long-term patients who are on Anthem. The claims processing takes more time than I would like, and the reimbursement rates are so low that if I were not committed from my own values stance to keeping this as part of my practice, I would certainly move to not accepting insurance." – Counselor

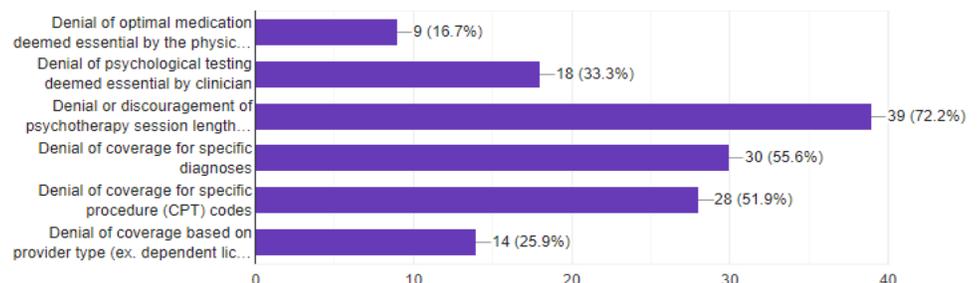
"Claims processing is full of needless red tape. There are frequent, time-consuming processes that take away from my ability to provide direct services. Compensation from reimbursement is also below market standards. I have no compelling reasons to continue accepting insurance aside from fulfilling my contracts I have with insurance companies I am paneled with." - Psychologist

3) Claims denials have outsized influence on clinical practice and can disrupt care

When asked about types of claims denials, most of the respondents had received denials related to specific diagnosis, session length, or specific CPT code. Responses related to psychological testing and optimal medication may be skewed due to these services being within scope for only some of the provider-types polled. When accounting for provider's scope of practice, the responses to type of denials indicate that every respondent has experienced claims denials challenging medical necessity. The qualitative responses indicated a sense of frustration and confusion for ongoing denials that usurp the clinician's assessment of necessity. . Diagnosis and intervention decisions are best made by those in relationship with the clients, informed by evidence. Our Coalition is concerned that repeated claims

Regarding provision of treatment, have you experienced any of the following insurance denials? (Check all that apply)

54 responses



denials for medical necessity reasons have undue influence on clinical decisions as clinicians adapt their practice to avoid administrative burden.

"[...] The reason I freelance is due to unrealistic expectations of the treatment centers in our area. I interviewed recently and was asked if I could see three patients in one hour for individual sessions. The average size caseload for methadone treatment is 70 to 90 patients. In Suboxone treatment the caseload is 65 patients. There are also assessments that need to be conducted, two hours of group therapy every day, that also have to be filled by the counselors. Each of these facilities enter into contracts with the insurance companies and they decide what the course of treatment will be for the patient, as per the contract. [...]" – Chemical Dependency Counselor

"Diagnosis helps providers streamline coordination of care. It is frustrating when a diagnosis is not covered by insurance, which would provide a record of a specific need and allow a referral for medication management or medically necessary services." – Counselor

"Since medical doctors, NPs, PAs, etc. can treat people for symptoms without a full-blown diagnosis, mental health providers should be able to treat symptoms of mental health conditions prior to the severity reaching full-blown mental health condition status. This is indicative of the bias in which our work is perceived as unnecessary until someone is in crisis. This is also indicative of the lack of parity between mental and physical health conditions. It is a detriment to clients/patients, who could have legal or occupational consequences from having to wait until their mental health is in shambles in order to receive help." – Psychologist

"Preauthorization for meds patients have been on for years is burdensome administratively and very disruptive to their care in terms of need for additional appointments and time to help them get on new meds when 3 attempts to authorize original medication are denied." - Psychiatrist

"Denial of claims and working to communicate with insurance companies is beyond difficult, withholding or even denying needed medical and therapy services for clients because of administration bureaucracy. I have had several clients become discouraged because both my client and I were unable to discover why their claim was denied in the first place." - Counselor

"Private insurance will not pay for telehealth they require face to face counseling. If a patient has had treatment in the past and walked off treatment the insurance company does not want to pay for another treatment episode. Everyone is having to preauthorize services before the patient starts treatment. Some insurance companies will only authorize one week of treatment at a time and I am referring to outpatient services." – Chemical Dependency Counselor

Other Comments:

"It is so challenging to onboard clinicians and get them credentialed with private insurance companies. Some take up to 90 days to finish credentialing (for LISW clinicians). This has made it difficult to provide services that are affordable for clients wanting to use their private insurance but don't want to wait for the credentialing period. Even simple address changes for clinicians can take 30-90 days." – Social Work

"Credentialing needs to be centralized. Not everyone uses CAQH. I want to be paid the same rate as a psychologist if I'm providing the same service. I also want my pay to be based on a standardized scale, not based on where I practice. Don't reject my application to be paneled by saying there are too many therapists in my area. This is so not true." – Social Work

"It would be helpful to have a streamlined claim system and process for determining reimbursement. The reimbursement rate swings wildly from insurance company to insurance company. It would be nice to be paid within 2 weeks. Sometimes I have to wait over 30 days for payment." - Counselor

"[...]I'm VERY concerned about insurance providers dictating where and when telehealth can be provided. What kind of a closed system is created when the insurers control the platforms for telehealth services? I've had very few no-shows as a result of using telehealth through the pandemic." – Psychologist

Conclusion:

We continue to be concerned that a small but significant portion of claims that require remedy are contributing to a very high administrative burden for behavioral health practitioners. In response to such a high administrative burden, some practices are shaping their services not based on clinical judgement or client need, but to reduce chances of a claim denial. Others are simply no longer taking insurance. Behavioral healthcare is essential healthcare. We hope to continue to work in collaboration with representatives from third-party payers to support our members in their efforts to provide high quality, accessible and affordable behavioral healthcare in Ohio.

About the Coalition:

Behavioral Health Providers for Insurance Advocacy strives to advocate for a more collaborative relationship with insurance providers, assure adequate reimbursement, improve access to the full continuum of care, using the expertise unique to behavioral health service providers. As a coalition we hope to support strong, two-directional communication with behavioral health providers through regular surveying of our membership, assessment of trends and recommendation sharing.

Member organizations:

National Association of Social Workers, Ohio Chapter

Ohio Psychological Association

Ohio Counseling Association

Ohio Psychiatric Physicians Association

Ohio Association of Drug Counselors

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