Working with MCO's

When asked about their views on Managed Care Organizations (MCOs), clinicians often respond with "they are a necessary evil," "they are evil" or "it's us against them." Very seldom will you hear a neutral or positive statement regarding the existence of MCOs.

MCOs are not new and there is no sign that they are going away anytime soon. Most clinicians find themselves dealing with MCOs, their paperwork, processes and reviews more than ever. Though these processes can be frustrating and time consuming, they can also have benefits as well, depending on the clinician & Care Advocates (CAs) relationship & attitudes, communication skills and level of respect.

This brochure is not designed to change clinician's feelings or opinions of MCOs, nor is it designed to explore any of the political arguments surrounding health care in the USA; it is designed to help improve the process of clinical reviews between clinician and CAs which can help increase the number of authorizations for sessions, decrease the length and frequency of reviews so that more time can be spent focusing on the client.

Regardless of personal views, MCO's are common; it is in the clinician's best interest to work well with them and foster a team relationship. Working within the system can assist the clinician and client by reducing obstacles and increasing access.

On the web: **www.docwarren.org**

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Tips to increase positive outcomes

- Review the client's chart prior to the meeting to refresh yourself with the entire situation.
- Don't feel threatened-no one is suggesting you are not doing your job correctly.
- Don't be on the defensive or offensive-be calm and professional.
- Be clear-you know this client better than anyone. Give the diagnostic issues based on the DSM, present symptoms, goals, interventions etc.
- Keep answers short-stay on task.
- Know the level of care guidelines.
- Keep sessions to 1 time per week, unless urgent need can be documented and only then increase sessions for a short period of time in order to stabilize.
- Be nice-how do you like to be treated? How do you respond best to people? Being rude, because you hate the process only makes the process longer and can create undue animosity. Being nice can make the CA advocate for you and your client. You may need their support in the future.
- Collaborate-the CA often has access to information that you may not. Ask questions about your client's health, history etc. The CA may have information that was not shared or was minimized by the client. The CA may also be able to serve as a case manager to help facilitate services not offered by your office. ASK!
- Know best practice guidelines and use them.
- Know parity laws and regulations as well as their limitations.
- Create a team-work as a team with the CA, building a partnership with the CA creates ownership in the client's treatment and often increases advocacy rates and incentives.

Community Counseling of Central Connecticut Inc.

Managing with Managed Care

A quick reference / survival guide for outpatient clinicians

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The Process*

When a CA calls the office to perform a review they are not calling to second guess, overrule or ridicule the clinician. They are performing a review to ensure that all that can be done for a client is, but also to ensure that there is no needless duplication of service, excessive amounts of service that could foster overdependence on the clinician on the part of the client. They also want to ensure that the treatment is as cost effective as possible. This sometimes leads to disagreements in treatment planning which may lead to the clinician and or the client filing an appeal (the appeals process is beyond the scope of this brochure and differs from company to company).

For the most part, the review process can be positive or at worst neutral- they rarely need to be seen as negative. The CA is looking for clear and concise information pertaining to the client and their treatment. The clinician's job is to supply the information so that a professional collaboration can occur.

Reviews can take as little as 5-15 minutes, provided the communication remains cordial and the information presented is clear. They can take up to or over an hour in situations where information is lacking or the relationships are strained.

Once the information has been collected, authorizations usually follow as will information pertaining to the need for future reviews.

Additional copies can be downloaded at http://docwarren.org/images/Managing_With_Managed_Care.pdf

*This section is not meant to be all inclusive, information needs vary from situation to situation

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Examples for Treatment Plans/Reviews

Diagnosis
- Use accurate DSM IV-TR diagnoses, including codes. Be specific- "she worries a lot" or "he is angry" are not valid diagnoses.

Symptoms:
- Depressed mood, anhedonia, anxiety, social isolation, agitation, delusions, hallucinations, anger outbursts, fatigue, psychomotor retardation, flat affect, low self-esteem, sleep disturbance, decreased appetite, suicidal ideation

Treatment Goals:
- Decrease depression, improve coping skills, increase self-esteem, stabilize mood, improve regulation of affect, foster insight, improve marital relationship, improve level of functioning.

Interventions
- Cognitive reconstruction, reframing, problem-solving,, identifying triggers, psychoeducation re: alternative coping strategies, collateral couple's sessions, journaling, relaxation training, systematic desensitization, exposure/ response prevention, safety planning, refer for med.eval.

GAF/ Est. Length of TX
- GAF can be very subjective-refer to DSM IV- TR for guidance.
- Length of treatment-Best guess-not binding.
- "When she has returned to her level of premorbid functioning. When he is able to significantly reduce or eliminate his panic attacks. When his depression has decreased to a minimal level."

Effective and proactive treatment planning is the best approach to reduce review times and ensure positive outcomes for your clients as the information sought in the review process is often found in the clients' DSM IV TR assessment and master treatment plan. A brief outline follows:

Diagnosis-be prepared to provide a detailed diagnosis. Know all 5 axis and their meaning. When asked for **symptoms**, use the DSM as a guide. Know the difference between a diagnosis and a symptom. "They worry a lot" is a symptom- it describes their behavior; "they have Anxiety D/O NOS" is a valid and easily understood diagnosis.

Treatment goals should be able to be measured (though you do not have to measure them), they do not need to be overly complicated- "decreased depression" in a depressed client is valid. Goals should be targeted to the symptoms. **Interventions** should be clear treatment techniques, avoid the common mistakes such as "behavioral therapy" or "psychoanalytical therapy" as those are theories and NOT techniques.

GAF-perhaps the most subjective part of diagnosing clients but still very important. Be as accurate as possible- again use the DSM as a guide. Clients in outpatient care typically fall between 60-75 range; if the client does not, this may indicate that the level of care needs to be adjusted. **Estimated length of treatment**, is very difficult to do with any certainty-guesstimating is the norm. Try to imagine what the client would look like if they were ready to discharge: what would they have achieved? Give a ballpark guess as to how long it will take to get there. This is not a binding estimate.

Additional clinical resources can be found at:
http://www.docwarren.org/comcounselingreview.html