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## CHAPTER 1

# Treatment in a Changing Health Care Environment

The primary purpose of this book is to help mental health professionals in typical outpatient settings provide the best empirically supported treatments for the major anxiety disorders and depression. We wrote the first edition of this book during the height of the managed care movement. It was a time of anxiety for many clinicians, as they found themselves for the first time having to seek approval for treatment from their patients' insurance companies. A secondary goal of the first edition was to help therapists navigate the managed care system by providing guidance in how to write treatments plans that managed care reviewers would approve.

Much has changed in the health care environment since that time. Over the last decade, many managed care companies have become less stringent in their requirements for clinical review and preapproval (Horgan, Garnick, Merrick, & Hodgkin, 2007). Recent developments, however, may reverse that trend. The Mental Health Parity and Addiction Equity Act, passed in 2008, requires insurers to provide the same coverage for mental disorders that they do for other medical conditions. This includes provisions that the degree of clinical review required be the same. However, as regulations related to the 2008 act have gone into effect, there is already indication that some insurers are again tightening their requirements for managed care review (Clemens, 2010). In addition, the future effects of health care reforms enacted under the Affordable Care Act of 2010 are, at this writing, uncertain.

Whatever further changes occur, it is clear that there will continue to be competing pressures to provide high-quality care while containing costs. Across all branches of the health care field, the use of empirically supported best practices is seen as crucial in attempting to meet these goals. Therapists can expect to have to continue justifying the treatments they provide to patients.

One of the advantages of using the cognitive-behavioral treatments described in this book is that, because they have been shown in studies using real patients to provide relief for depression and anxiety disorders, therapists can know and represent to insurers that they are providing high-quality care to their patients. In addition, because these treatments are designed to be relatively short-term, there are likely to be viewed favorably by managed care companies and other entities in the health care system whose role it is to control costs.

The managed care industry has adopted several of the basic assumptions that underlie

cognitive-behavioral approaches to mental disorders. Understanding these assumptions (even if you don't necessarily agree with them) will help both in dealing with managed care reviewers and in applying these treatments to patients.

Three key assumptions shared by managed care and cognitive-behavioral approaches are as follows:

- 1. Symptoms are the problem. Rather than viewing symptoms as signs of "deeper" issues that must become the target of treatment, cognitive-behavioral approaches focus on patients' symptoms as the problems to be solved. Therefore, the disorders to be treated are defined by patients' symptoms and the impairments in daily functioning they cause.
- 2. Symptom relief is the goal. Because symptoms are viewed as the problem, the goal of therapy is the reduction or elimination of those symptoms. In order to show that treatment has been effective, there must be some means of measuring changes in symptom severity and improvements in functioning.
- 3. Treatment interventions must have scientific evidence of effectiveness in reducing symptoms. Cognitive-behavioral researchers develop treatment techniques based on their theoretical understanding of the disorder being addressed. However, these techniques are not considered valid until they have been shown in clinical studies to reduce symptoms effectively. Often researchers will compare the effectiveness of different cognitive-behavioral techniques to determine which technique or combination of techniques is most effective.

In summary, cognitive-behavioral researchers (and most managed care reviewers) assume that patients' symptoms dictate the goals, which in turn dictate the empirically validated treatment techniques to be used.

The assumptions outlined above influence who gets approved for treatment by managed care companies (patients who meet criteria for a mental disorder; see "Medical Necessity," below), what types and lengths of treatment are approved (brief, empirically supported treatments such as cognitive-behavioral therapy are preferred), and even what questions are asked on treatment reports (evidence of symptoms and impairments consistent with a diagnosis; what techniques that will be used to target specific symptoms; measurable goals and outcomes). The rest of this chapter provides suggestions on how to use an understanding of these assumptions to increase the likelihood of getting treatment approved.

Chapters 2–8 of this book describe cognitive-behavioral treatment packages for specific disorders. These chapters follow the basic logic of symptoms leading to goals leading to interventions; as such, they guide therapists through the process of working with patients, from assessment to theoretical formulation to implementation of treatment. Topics covered in each chapter include the following:

- A description of the disorder and related features
- A cognitive-behavioral conceptualization of the disorder
- A brief review of the outcome literature supporting the use of specific interventions
- Detailed instructions for assessing and treating patients, including patient handouts and homework forms

- Hints for troubleshooting common problems in therapy
- Sample symptoms, goals, and interventions to be used in writing treatment reports
- A detailed plan of treatment options
- A case example

## **GETTING APPROVAL FOR TREATMENTS: GENERAL CRITERIA**

Getting approval from managed care companies—particularly for the kinds of treatments described in this book—need not be a nerve-wracking experience, provided you understand what reviewers are looking for. Although you may still encounter restrictions on treatment, following the recommendations in this chapter should increase the likelihood of getting a favorable response.

Virtually all companies require that two basic criteria be met before a treatment plan will be approved: (1) medical necessity and (2) appropriate treatment. Let us look more closely at what these entail.

#### **Medical Necessity**

"Medical necessity" is determined by the patient's symptoms. In order for treatment to be considered medically necessary, the patient must meet criteria for a mental disorder as defined by the current version of the *Diagnostic and Statistical Manual of Mental Disorders* (at this writing, DSM-IV-TR; American Psychiatric Association, 2000), which include evidence of distress or impairment in social, occupational, or educational functioning. Reviewers check whether the specific symptoms and mental status described on a treatment report are consistent with the diagnosis shown, and whether there is evidence of sufficient impairment to justify treatment.

## Appropriate Treatment

"Appropriate treatment" involves both the goals of treatment and the interventions used to reach those goals. Goals must relate to the reduction of the patient's symptoms or to amelioration of impairments, and they should be specified in terms that can be measured.

When evaluating interventions, reviewers typically consider two questions: (1) Does the level of care match the severity of the patient's symptoms? (2) Is the treatment approach appropriate for the symptoms? "Level of care" has to do with the intensity of treatment—that is, whether the patient should be hospitalized, placed in a partial hospitalization or day treatment program, or seen in an outpatient setting. If the patient is seen on an outpatient basis, level of care also involves how often the patient is seen. Many companies will not approve sessions more than once a week unless the patient is clearly in crisis and/or unable to carry out routine daily functions, such as work or child care. Meeting more than twice a week is unlikely to be approved unless the patient is actively suicidal or homicidal and an argument can be made that intense outpatient treatment will prevent hospitalization.

The treatment approach must also be judged appropriate for the patient's symptoms. For example, a treatment plan for a patient with a bipolar disorder that includes intensive psychotherapy but no medication is likely to be questioned. The treatment techniques described in this book, because they are empirically validated and specific to each disorder, will almost always be considered appropriate treatment.

### THE INITIAL TREATMENT REPORT

Each managed care company has its own form for filing treatment reports. However, the key elements are the same for all reports and cover the three key areas discussed above: symptoms, goals, and interventions. Symptoms are assessed in most treatment reports by questions related to the patient's DSM diagnosis, presenting problem, mental status, and level of impairment. Many reports request specific goals. Interventions are assessed by questions related to frequency of visits, type of therapy provided, and medication. Some reports request the specific types of interventions to be used for each goal listed. Outlined below are guidelines for completing the sections found in a typical treatment report.

Please note that before completing any managed care reports, you should familiarize yourself with the laws governing patient records in your state or jurisdiction. Some states have laws that are more restrictive than the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). When state law is more restrictive, it prevails, and you may not be able to release all of the information requested on the report or described below.

## Symptoms

#### Diagnosis

Be sure that the diagnosis is accurate and complete. Underdiagnosing a patient may result in fewer sessions' being approved or in questions' being raised when additional sessions are requested. However, you also cannot give a patient a more severe diagnosis for which he or she does not meet criteria. Giving a patient an inaccurate diagnosis in order to obtain services is unethical and constitutes insurance fraud.

List all DSM disorders for which the patient meets criteria. The presence of comorbid conditions may complicate treatment, and the reviewer should be aware of this from the start. Be aware that some companies will not cover treatment of certain disorders—for example, sexual dysfunctions or personality disorders. Some companies require that any patient with a primary or secondary diagnosis of substance abuse or dependence be evaluated and treated by a clinician with special certification in substance abuse treatment (e.g., a certified alcoholism counselor). In general, "V-code" diagnoses will not be covered. Marital/couple therapy is also not covered by most companies. However, if one of the partners meets criteria for an Axis I mental disorder, some companies will cover conjoint therapy with the spouse participating, as long as the treatment goals relate to the symptoms of the partner who is the identified patient.

#### Presenting Problem

The section on the presenting problem should cover three areas: (1) precipitating events or stressors, (2) specific symptoms, and (3) impairments in life functioning.

- 1. **Precipitating events.** Briefly list the events that have resulted in the patient's seeking treatment at this time. Protect the patient's confidentiality by giving only enough detail to indicate the level of stress. Any known history of physical or sexual abuse or other trauma should be noted here.
- 2. Specific symptoms. This is not a place for creative writing. Get out the DSM, or the tables listing sample symptoms in this book, and simply list the criteria that the patient meets for each disorder. Remember, reviewers are going to check off these symptoms to make sure the patient meets the diagnosis. You might as well make their job easy.
- 3. **Impairments.** Indicate how the specific symptoms interfere with the patient's functioning. Be sure to note any impairments in work, school, parenting, marital/couple, or social functioning.

## Mental Status

Some treatment reports provide a checkoff list for evaluating mental status. Others request a brief written mental status report. The key elements of a mental status report are as follows (see also Sadock, Sadock, & Ruiz, 2009):

- Appearance. Describe the patient and note anything unusual in his or her appearance (e.g., marked obesity, poor grooming, unusual clothing or makeup).
- Attitude. Describe the patient's attitude toward you as the therapist (e.g., cooperative, guarded, belligerent, seductive, etc.).
- **Consciousness.** Is the patient alert, or is there some impairment in consciousness (e.g., drowsy, clouded, unconscious)?
- Orientation. Is the patient aware of (1) person (who he or she is, who other people present are); (2) place (where he or she is); and (3) time (date, day of week)? If the patient is oriented in all three areas, this is often abbreviated as "oriented times three" or "oriented × 3."
- Memory. Note any deficit in immediate, short-term, or long-term memory.
- **Psychomotor activity.** Describe any abnormalities in the patient's movement (e.g., agitation, retardation, nervous tics, etc.).
- Speech. Note anything unusual in the rate, tone, or volume of speech (e.g., slow and halting, rapid, pressured, barely audible, high-pitched).
- Mood. Briefly describe the patient's mood, either as the patient reports it or by observation (e.g., anxious, depressed, calm, angry).
- Affect. "Affect" refers to the manner in which the patient's mood is expressed. Normal affective response is described as "full range," indicating that the patient is able to express a variety of emotions. Common variations in affect include "restricted" (ability to express only one or a few emotions); "blunted" (emotions are present, but their expression is muted); "flat" (lack of emotion); "labile" (rapid swings between emotions); and "inappropriate" (emotion does not match the situation or content of what is being discussed).
- **Perception.** Indicate any abnormalities of perception, such as visual or auditory hallucinations, depersonalization, or derealization.
- **Thought content.** Indicate any abnormalities of expressed ideas, such as delusions, persecutory ideation, or ideas of reference. Also note any suicidal or homicidal ideation.

- **Thought process.** The thinking of patients who can stay on topic is described as "goaldirected." Variations in thought include "circumstantial thought" (excessive detail), "tangential thought" (going off topic), "loose associations" (jumping from one topic to another with no apparent logic), and "perseveration" (returning to the same topic repeatedly).
- Judgment. "Judgment" refers to the patient's ability to make sound decisions in social situations and to understand the likely consequences of behavior. Judgment is typically described as "poor," "fair," or "good."
- Insight. "Insight" refers to the degree to which the patient is aware that he or she has a problem or is ill.

The mental status report should support the diagnosis. For example, a patient who is depressed may be expected to have depressed mood. In addition, such a patient may or may not have psychomotor retardation, halting speech, constricted affect, and suicidal ideation.

## Goals

Whenever possible, treatment goals should be stated in terms that are observable and measurable (e.g., specific countable behaviors, scores on assessment instruments, client reports). Goals may cover the following areas:

- 1. Completion of tasks required as part of treatment. Examples: (a) completing exposure to all avoided situations; (b) engaging in one pleasurable/rewarding activity daily; (c) acquiring assertion skills.
- Relief of specific symptoms. Examples: (a) eliminating intrusive memories of trauma;
  (b) reducing self-critical ideation; (c) reporting anxiety below 2 on a scale from 0 to 10 in business meetings.
- 3. **Reduced impairment.** Examples: (a) bringing grades up to prior level (A's and B's); (b) resuming all household activities; (c) beginning to date; (d) finding appropriate employment.
- 4. Cognitive change. Examples: (a) stating less than a 10% belief in assumption of need for perfection; (b) modifying schema of worthlessness.
- 5. End-state goals. These are goals that will indicate that treatment has been successfully completed. Examples: (a) eliminating all depressive symptoms (Beck Depression Inventory–IL score under 10 for 1 month); (b) engaging in all previously avoided activities; (c) eliminating panic attacks.

## Interventions

## Treatment Frequency and Type; Specific Techniques

Some treatment forms request only basic information about the treatment: frequency and length of sessions, type of therapy (e.g., cognitive-behavioral, psychodynamic, systems), and format (individual, conjoint, family). Others request more specific information about the types of interventions to be used to meet each goal. In such cases, the specific techniques described in the treatment packages in this book can be listed. Sample goals and corresponding interventions can be found in Chapters 2–8, as well as on the CD-ROM.

#### Treatment in a Changing Health Care Environment

### Medication

Most treatment forms request information regarding what medication, if any, the patient is receiving. If the patient is not taking medication, it can be helpful to indicate that the patient has been educated regarding the advantages and disadvantages of medication (which should always be done). It may also be helpful to give a rationale for why medication has not been chosen as an option. Symptoms in the mild to moderate range, lack of suicidal or homicidal ideation, and good initial response to psychotherapy are generally acceptable reasons to proceed without medication. However, expect that if the patient does not show improvement, reviewers may request that the patient receive a medication evaluation. , Pres

## Sample Treatment Report

Figure 1.1 shows a sample treatment report.

## **REQUESTS FOR ADDITIONAL SESSIONS**

Few managed care companies will authorize more than 10-12 sessions on the basis of an initial treatment report. This means that you will often need to file subsequent treatment reports requesting additional sessions. In evaluating such a report, reviewers generally look for two things: (1) evidence that the patient is making progress, and (2) the continued presence of symptomatology that makes additional treatment necessary. If the patient has not progressed, reviewers are likely to question the efficacy of the treatment and may suggest alternative treatment or disallow further sessions. If the patient no longer has symptoms, the reviewers will obviously consider treatment no longer medically necessary. Outlined below are things to consider when you are writing requests for additional sessions.

## **Progress Made in Treatment**

Most treatment forms ask for some accounting of the progress the patient has made since the prior report. Progress should be described in relation to the symptoms (including impairments), goals, and interventions included on the initial treatment report (see below for specific suggestions regarding each of these). Remember, if you cannot document that your patient is making some progress, you may have trouble getting additional sessions authorized.

You should also note any conditions that have interfered with progress in treatment. If the patient has been subjected to a new stressor that has exacerbated his or her condition, this should be noted. For example, a depressed patient who has been laid off from his or her job since the last treatment report may reasonably be expected to have a temporary increase in symptoms. Most managed care companies will make allowances for such occurrences. In addition, if the patient is resistant to treatment in some way, this should be noted, along with the steps that are being taken to address the resistance.

## **Changes in Symptoms**

#### Diagnosis

If any additional diagnoses have become apparent during your work with the patient, be sure to add the appropriate diagnostic codes. Comorbid conditions may slow progress, and the reviewer

#### Symptoms

#### Diagnosis

Axis I	300.23 Social phobia (social anxiety disorder) 296.21 Major depressive disorder, single episode, mild
Axis II	None
Axis III	None
Axis IV	New job
Axis V	Current: 55
	Highest: 80

#### Presenting Problem

Patient recently took a new job that requires public speaking. Patient has long-standing fear of public speaking and has avoided it in the past. He has responded by becoming very anxious and depressed in last month. Specific symptoms: Intense fear of anticipated speech, avoidance of public speaking, stomach cramps, muscle tension, insomnia, fatigue, impaired concentration, depressed and anxious mood, loss of appetite, weight loss, and feelings of worthlessness and guilt. These symptoms interfere with work functioning.

#### Mental Status

Patient is a 26-year-old white male. Appears stated age. Well groomed. Cooperative. Alert and oriented × 3. Memory intact. Movement normal. Speech soft. Mood depressed and anxious. Affect constricted. Thoughts goal-directed. No psychotic symptoms. Denies suicidal or homicidal ideation. Insight and judgment good.

#### **Goals and Interventions**

Treatment goals	Interventions
Reducing physical anxiety symptoms	Exposure
Reducing fear of public speaking	Cognitive restructuring, exposure
Engaging in three public speaking activities	Public speaking group
Completing speaking assignment with anxiety level of 2 or less on a scale of 1–10	All of the above
Eliminating ideation of worthlessness and guilt	Cognitive restructuring
Engaging in one rewarding non-work-related activity/ day	Activity scheduling
Stating reduced belief (10%) in assumption of need for perfection	Developmental analysis, cognitive restructuring
Returning to previous level of work functioning	Cognitive restructuring, exposure
Eliminating anxiety and depressive symptoms (BDI-II	All of the above
score 10; Millon Clinical Multiaxial Inventory score in	
normal range).	

#### Medication

None. Patient has been educated regarding costs and benefits of medication. Does not wish to consider medication at this time. Symptoms are mild and of brief duration.

#### **Frequency of Sessions/Expected Duration of Treatment**

One 45-minute session per week; 12-16 sessions.

FIGURE 1.1. Sample treatment report (BDI-II: Beck Depression Inventory–II).

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should be made aware of this fact. Conversely, if the patient no longer meets criteria for one of the original diagnoses, or if the level of severity has changed (e.g., on a diagnosis of major depression), this should be noted. Also note any change in functional impairment.

## Presenting Problem

List all specific symptoms and impairments that the patient continues to have. If some symptoms or impairments remain but have lessened in intensity or frequency, note that. As before, these should correspond to DSM criteria for the patient's diagnoses. Even if some symptoms have remitted, additional treatment is likely to be approved if other symptoms are still present and there continues to be some impairment in functioning. Be sure to list symptoms and impairments for any additional diagnoses that are included.

## Mental Status

Note any changes in mental status. As before, the mental status report should support the current diagnosis or diagnoses and the progress made in treatment. For example, if a depressed patient no longer has suicidal thinking, psychomotor retardation, or constricted affect, these changes should all be reflected in the mental status.

## **Changes in Goals**

Note which goals from the original treatment report have been fully or partially met. Add goals related to any new diagnoses, specific symptoms or impairments, or life stressors. If it was not included in the first treatment report, it may be advisable to add the acquisition of relapse prevention skills as a goal.

## **Changes in Interventions**

## Treatment Frequency and Type; Specific Techniques

Note any changes that have been made in treatment frequency or type, as well as in specific treatment techniques employed. Be sure to give the rationale for these changes and to describe the patient's response to them.

## Medication

Note any changes in the patient's medication or dosage, along with the rationale for the change and the patient's response.

## Justification for Continued Treatment

Some forms request reasons for continued treatment. The explanation should be brief and summarize what has been included on the rest of the form. Progress that the patient has made should be noted, along with any new stressors, followed by a description of remaining symptoms and impairments. If a change in the patient's condition or life circumstances has necessitated new treatment goals, these should be highlighted. The need for continued treatment should be based on the continued presence of symptoms and on the need to prevent relapse.

## **TELEPHONE APPROVALS**

Some insurance plans require that approval be obtained by phone rather than by written treatment report. For some clinicians, this can be especially anxiety-provoking (after all, rejection in person is harder to take than rejection by letter). However, the same principles apply in obtaining approvals via telephone as in submitting written reports. Reviewers want evidence that the treatment is medically necessary and appropriate, and, on subsequent approvals, that the patient is making reasonable progress while continuing to require treatment.

Two key principles to keep in mind when talking to reviewers by phone are these: (1) Be courteous; and (2) be professional. Taking an adversarial stance is not likely to help. What will help is being prepared. Before calling, you should have thought through (and possibly written out) all of the information that would be required on a written treatment report. This will enable you to answer the reviewer's questions clearly and succinctly. It has been our experience that describing a cognitive-behavioral treatment plan with specific techniques and an expectable short-term course makes approval more likely.

# REQUESTS FOR EXTENDED TREATMENT

Managed care companies vary in the degree to which they are willing to approve sessions beyond a typical course of 16–20 sessions. For those companies that will consider longer treatment, we have found that the following indications make approval more likely:

- 1. More severe symptoms and impairments.
- 2. Suicidal or homicidal ideation.
- 3. A life crisis that has arisen during the course of treatment.
- 4. Clearly specified goals for continued treatment.
- 5. Evidence of progress between treatment reports.
- 6. Utilization of adjunctive treatments, such as medication or support groups.

This information must, of course, be accurate and must be supported by session notes.

#### Session Notes

Some managed care companies will request copies of session notes. Depending on state law, insurers may have the right to review a patient's complete record. This raises a dilemma for clinicians, who, in addition to needing to document their treatment adequately for clinical purposes, must be concerned with protecting patients' privacy while at the same time being mindful of the

need to justify treatment to managed care reviewers. In trying to strike the best balance of too little versus too much information, it can be helpful to consider exactly what reviewers will be looking for in session notes. In short, for the purposes of managed care approval, treatment notes should include data that support the diagnosis and treatment plan consistent with the guidelines outlined above. Therefore, each session note should include a description of the patient's status, age in , and any including the nature and severity of symptoms and distress that day, and any change in the presence or severity of symptoms; a description of interventions used in the session; and any progress made on patient goals.

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