Survey of Managed Care Practices Affecting Clinical Social Workers

From December 2015 to January 2016, we surveyed all members of NYSSCSW online about their experiences with commercial mental health insurers. Of the 1,625 Society members, 227 responded to the survey.

Comprising 25 questions, the survey asked for descriptions and comments to explain the answers. A majority of respondents were dissatisfied, some intensely, others by degrees. Here is a review of the varied answers to the first survey question.

Question: Insurers require you to show medical necessity to justify further treatment. Have you experienced a misuse of this requirement?

Response: 52% answered Yes; 48% answered No. These are typical comments:

- This system is not good for patients with a long history of mental illness.
- Serious diagnoses are not treated as needing appropriate care (a frequent comment). Reviewers don't like long term psychotherapy, even when it is helping the patient.
- Twice-a-week treatment is not authorized except for extreme situations. Twice-a-week visits are targeted for review.
- The concept of medical necessity is also not appropriate for patients with mild diagnoses. The clinician needs to use biological diagnoses, such as MDD, GAD, or PTSD, to be sure of authorization.
- Authorization for continued treatment was tied to patient accepting medication. There was no concept of self-determination if patient did not want medication.
- Insurer disregarded patient's request for appeal.
- Insurer discontinued care when patient was suicidal and denied it was their responsibility.
- Reviewers are unfairly probing or challenging, asking intrusive questions, such as questions about domestic violence.
- Reviewer gave specific recommendations on how to provide treatment or required a modality with which the clinician did not agree.
- Reviewer could not state clearly the criteria for medical necessity.
- Decisions were based on little information.
- Reviewer was a clerk, not a trained professional.
- There were inconsistent responses from the same reviewer (for example, patients were deemed either too sick or too healthy for once-a-week therapy).
- Sessions were authorized and later denied by a supervisor.
- Failure to gain authorization caused a delay in treatment.
- Reviews are used to curtail treatment based on number of sessions (a frequent comment). This occurs despite advertisements stating that the patient will receive "unlimited sessions."
- Reviewers have admitted they are guided by numbers. It feels like the review is based on a pre-arranged number of sessions, for example, 20. The reviewer seems to have an outcome in mind before the call. It feels like game-playing.
- Time spent gaining authorization is an abuse in itself, i.e., wasteful.

[Insurers mentioned: UBH, Value Options, Cigna, Multiplan, Emblem/GHI, Aetna and Magellan. Note that not all responses were negative. Some respondents had had no contact with insurers for many years, or they were not on panels, or they found a reviewer "respectful and collegial."]

By Helen T. Hoffman, LCSW, Chair of the Vendorship and Managed Care Committee

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January 2016 Online Survey of the NYSSCSW Membership: 227 Members Responded

Question Number	TOPIC	% YES	% NO	Number of Responses
Q 2	Misuse of medical necessity	52%	48%	221
Q 4	Denial of treatment or caps on visits	53%	47%	226
Q 6	High deductible prevented continuity of treatment	62%	38%	135
Q 8	Telephone reviews in past 5 years	72%	28%	224
	Number of reviews:	1–6	46%	
		Over 6	26%	
Q 11	Difficulty getting on panels	38%	62%	212
Q 15	Difficulty leaving panels	21%	79%	170
Q 17	Removed from panels	3%	97%	207
Q 19	Treatment affected by reduction in out-of-network benefits	56%	44%	212
Q 21	Income reduced by out-of-network benefits	64%	36%	213
Q 23	Difficulty finding in-network psychiatrist	85%	15%	213
Q 24	Difficulty finding in-network psychotherapist	62%	38%	212
Q 25	LCSWs excluded from insurance	None reported except Ford		

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