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Short Review

How US Insurance Companies Limit and Deny Payments for Mental Health Services

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Abstract

In the United States, insurance companies make it very difficult, and sometimes impossible, to provide mental health services. The author describes the insurance tactics and strategies he encountered while running an outpatient psychotherapy program for survivors of severe childhood trauma. After four years, the author had to close the program despite having 30-40 patients enrolled per day in the months prior to closure. This was due to low reimbursement rates and a set of denial strategies described herein.

Keywords: *Insurance companies, Mental health, Denial of service*

Despite an epidemic of deaths due to opiate overdoses, gun violence, drunk drivers, and suicide in the United States, insurance companies and the federal government make it difficult, and sometimes impossible to provide mental health services. This is due to low reimbursement rates for services and an array of denial strategies. The author owned and ran an outpatient psychotherapy program for survivors of severe childhood trauma for four years but it had to close effective August 16, 2024. During those four years, the author, who was the Medical Director, received no salary and the Chief Operating Officer (COO) worked extremely long hours resulting in severe burnout and strain on her physical and mental health. Despite her unflagging dedication to the program and the patients, she tendered her resignation in June, 2024. Citing overwhelming burnout, the Clinical Directors for the two Trauma Recovery Institute (TRI) program sites also tendered their resignations in the same month. It was not financially possible to hire sufficient support staff to reduce the stress level for the Clinical Directors.

TRI provided a Partial Hospitalization Program (PHP) and an Intensive Outpatient Program (IOP) both in person and by telehealth. The PHP provided 4 hours of group therapy per day Monday to Friday plus one hour of individual therapy per week. The IOP provided the same content but for 9-12 hours per week, and no individual therapy. TRI groups were highly structured and patients were provided with 91 pages of spiral-bound lesson plans that matched the different groups. Treatment included educational, cognitive-behavioral, systems and experiential approaches with a lot of focus on self-regulation skills and work with dissociated self-states. Patient acuity levels were high and meaningful treatment could not have been provided by skeleton staff. The average length of stay in the Program was 48.4 days (SD=38.0). Almost all patients admitted to TRI met criteria for Complex PTSD and/or a dissociative disorder as well as major depressive disorder, generalized anxiety disorder and multiple other comorbidities. Treatment was based on a well-defined treatment model that has been the basis of a series of prospective treatment outcome studies and is evidence-based at Level 2 of the US Public Health Service criteria, which require multiple prospective cohort studies but not randomization or a control group. All these studies were conducted with no external or grant funding [1-11].

Denial by Medicare

Even though Medicare pays more poorly than commercial insurance, the author wanted to provide services to individuals on Medicare because he had done so through hospital-based Trauma Programs for 31 years. Those programs were closed in 2020-22 by the hospitals with which he was an independent contractor despite their maintaining a stable census. The three hospitals – one in Texas, one in Michigan and one in California - decided that they could fill the beds without paying the management fee for the author so they closed the Trauma Programs. Most patients met criteria for PTSD and dissociative identity disorder or other specified dissociative disorder. In July, 2020 TRI applied to be enrolled as a Medicare provider. The application was processed and accepted and in August, 2021 TRI was told by mail that that the application had been forwarded to the state of Texas for final approval. During that year the COO had made dozens of phone calls and sent dozens of emails to Medicare with no responses. The phone number provided to reach out to the state with questions was no longer in service according to the message played when it was called. Then in July, 2022 TRI received a letter saying that Medicare had received a letter from TRI asking for is application to be withdrawn – no such letter was ever sent. Numerous phone calls did not yield any information as to how or where to reapply. Then in November, 2022 TRI received a letter from Medicare saying that its enrollment with Medicare was being cancelled because it had not treated any patients.

Insurance Denial and Cost-Escalation Strategies

Insurance company strategies for denial of payments and escalating administrative costs for providers include:

1. If they issue a physical check that doesn't arrive, they won't issue a replacement check for 60 days. They require the provider to say which patient the check was for, but they don't say in any of their payments which patient a check is for; in addition, they tell the provider that they can't tell them which patient a check is for.
2. They state that decisions about the need for treatment are made by the doctor, not by the insurance company, but then they deny payment on the grounds that there is no medical necessity.
3. When a provider gets in network with an insurance company, the provider is not told that there are some policies for which the provider is not in network. The insurance company does not require prior authorization for that provider but when the provider submits a claim, the insurance company says that the provider is not in network with that particular sub-policy. The insurance company does not inform the provider in advance that the provider's *in network* status with that company does not apply to all policies.
4. The insurance company denies payment for treatment provided because no prior authorization was obtained, even though it says in insurance company paperwork that no prior authorization is required.
5. Insurance policies often have deductibles of $5,000.00-$10,000.00 which start anew every January 1 – as a result patients have to stop treatment until their deductible is met because they can't afford it. They pay for insulin, cardiac medications or other expenses till their deductibles are met.
6. The insurance company gives only a few days notice that they aren't going to pay for anymore treatment, even though the patient clearly meets criteria for ongoing treatment.
7. When the provider calls the insurance company about a claim, the wait time for someone to answer can be an hour.
8. When a human being does answer, the information provided is often different from that provided on previous calls and on subsequent calls.
9. Escalating a denied claim to a supervisor is often difficult or impossible.
10. Not processing claims at all or not for long periods.
11. Not sending information about which payment is for which patient, which requires inordinate time on the provider's end to sort out and reconcile everything and maintain an accurate accounts receivable.
12. Freezing reimbursement rates without a cost of living adjustment while provider costs inflate substantially.
13. Denying treatment altogether even for patients who are actively suicidal.
14. Employing reviewers who are actively hostile and belittling on the telephone – of both provider and patient.
15. Paying huge sums for new chemotherapy drugs that extend life by only a few months, and ICU stays at the end of life while nickel and diming mental health.
16. Routinely taking 6 weeks to pay for services after a billing is submitted.
17. Saying that the insurance company won't pay for anymore treatment because the patient isn't improving, is "at baseline" or has a chronic condition, while paying for renal dialysis, insulin, COPD treatment and numerous other maintenance treatments for chronic medical conditions, most of them more expensive than psychotherapy.
18. Using the diagnosis of borderline personality disorder to deny treatment.
19. Requiring inordinate amounts of utilization review by telephone, often resulting in denial of payment for treatment already provided.
20. Requesting medical records in order to pay for a claim when the records were provided at the beginning of treatment.
21. Approving a status for TRI such that pre-authorizations were no longer required but then denying payment because no pre-authorization was obtained. Insurance company personnel answering the phone had never heard of the no pre-authorization required program and didn't know who we could talk to about it. This was a Texas program but is now being offered nationally by that insurance company.
22. The insurance company reviewer asks only set questions from a script about symptoms, diagnoses and medications and refuses to listen to or consider recent psychosocial stresses.
23. Multiple TRI clients ended up requiring inpatient treatment after the insurance company denied additional IOP treatment. This was not in the financial best interests of the insurance companies, which seem to have no procedure for monitoring such outcomes.
24. For multiple TRI clients, additional treatment was denied starting the day of the denial, resulting in TRI providing additional free care for adequate discharge planning, which is required by the insurance companies.
25. Paying only 90% of the contracted rate for PHP or IOP. However, if TRI billed above the contracted rate, the insurance company would pay 100% of the contracted rate. We found this out after a long period of providing treatment.

All the above tactics result in huge amounts of provider personnel time being expended, plus endless stress and hassle. All of these barriers to staying in business were compounded in early 2024 due to a global security breach that impacted insurance payment systems,

resulting in a 75% drop in revenue for 6 weeks. The likelihood of future such calamities was another strain and source of exasperation and stress.

Discussion

In the case of TRI, the treatment involved complex sub-specialty intensive psychotherapy. This required a lot of training and supervision by TRI supervisory staff. With the low insurance reimbursement rates, TRI could not afford to pay therapists an hourly amount that could compete with private practice, therefore TRI had to employ and train interns or pay more seasoned staff more than it could afford. Four years of not knowing whether we would be able to make the next payroll took their toll. If I had sold TRI to an investor, they would have destroyed it in short order by cutting costs, meaning cutting staff and putting so many people in each group that the quality of treatment was gone. There just isn't any political will to provide intensive, high-level psychotherapy to childhood trauma survivors in the United States – governments, insurance companies, politicians and medical schools talk the talk but none of them walk the walk. All the above problems were compounded by the fact that many TRI patients met criteria for dissociative identity disorder (DID) or other specified dissociative disorder: bias and prejudice against DID are endemic in the mental health field including at medical schools and in academic departments of psychology.

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